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ORIGINAL COMMUNICATIONS.

REMARKS ON THE TOXIC PROPERTIES OF SASSAFRAS. *By* JOHN BARTLETT, M. D., CHICAGO.

[Read before the Chicago Gynecological Society, November 27th, 1885.]

I wish this evening to call attention to a possible property of a medicine regarded up to a very recent date as almost inert.

Sassafras was discovered in Florida by the Spaniards and named by the French in 1562. It was used by them in association with other native herbs as a remedy for malarial diseases. For years past, though occasionally prescribed in combination in rheumatism and syphilis, and regarded as possessing diuretic, diaphoretic and tonic properties, it had become to be looked up as but little efficient. So that by referring to such books as were within my reach, namely, Motherby, 1785, Parr, 1809, Eberle, Trousseau, Mitchell, Warring, Stillé, Ringer, Bartholow, Phillips, Wood, Fluckeger, Farquharson, Brunton, Wormly and Blyth, and the U. S. Dispensatory, National Dispensatory, Christison's and King's Dispen-

satory, I can find no mention of the possession by sassafras of any decided therapeutical or noxious power.

More than twenty years ago Dr. Thompson, of Tennessee, stated that sassafras was an antidote to henbane and tobacco; and later, in 1870, Dr. Lyle, of Indiana, declared that he had used the oil of sassafras in a case of stramonium poisoning with the happiest results. Dr. Lyle affirmed that sassafras had power to destroy all insect life, and was an effectual antidote to the venom of the copperhead snake. In 1883 we find that Dr. Hinton claimed that sassafras tea was almost a specific for the rash produced by poison oak.

Recently paragraphs have appeared in the medical journals, in which it is stated that sassafras is not the innocent agent that it has been supposed to be, but that in reality it has violent toxic properties. This statement is made upon the authority of Dr. Charles L. Hill, from whose paper read before the 86th session of the Medical and Chirurgical Faculty of the State of Maryland, in April, 1884, the following report is extracted:

"A case of poisoning by the oil of sassafras, that once came within my knowledge, proved that it possesses far more active properties than is generally supposed, and I have been able to demonstrate by experiment on the lower animals that, instead of being a harmless, inert drug, it is a strong nervous sedative, anodyne and soporific, and in over-doses, a dangerous narcotic poison. A policeman, attracted by the sound of a falling window and other suspicious noises proceeding from a gentleman's office, entered the room to ascertain the cause. He found no one present but a boy, who was lying unconscious on the floor. He took him at once to the station-house, where I saw him shortly afterward. The officers had already diagnosed his case as one of opium-poisoning, and

were vigorously striving to keep him awake by walking, flogging and such other means as are usually resorted to in these emergencies. His stupor was profound and he no longer made an attempt to walk, but was literally dragged about in their efforts to revive him. He spoke occasionally, but only to beg them to allow him to sleep. He was in a condition of great relaxation; skin covered with a profuse perspiration; countenance pallid; pulse rapid, but weak and thready. His pupils were *normal*, and there was a strong odor of sassafras in his breath. As quickly as possible an emetic was administered, which produced a copious emesis, redolent with the odor of sassafras, with drops of the undissolved oil floating in the liquid. This was followed by free draughts of warm water, until only a faint odor of sassafras was discoverable. The vomiting relieved him and he was soon restored to consciousness. He felt no discomfort except a sense of weakness and exhaustion, and was soon able to give the following account of himself: His employer having gone home, he was preparing to close up the office, when he espied a bottle of the oil of sassafras which had been left on the desk. Remembering that sassafras had been recommended for the removal of an eruption that disfigured his face, he thought this a good opportunity for giving it a trial, and turning up the bottle—to use his own language—he took two large swallows of its contents. In a few minutes he began to feel very *stiff*, as he expressed it, but proceeded to close up the shutters preparatory to leaving for home. He raised the window for this purpose, but had not strength to hold it in this position, and it dropped from his grasp, and at the same time he fell to the floor unconscious. This suggestive case led me to make numerous experiments on the lower animals with very interesting results. Ten drops of the oil were injected hypodermically under the skin of a

mouse. The animal quickly succumbed and died convulsed. By repeated experiments I was able so to regulate the dose as to get the characteristic effects of the drug without causing the speedy death of the mouse. A glass rod was dipped into the oil and held in front of the mouse, and he seized it with his mouth. This was repeated at intervals of a few minutes, until a sufficient quantity was taken to produce the desired effect. The first symptoms observed when a small quantity was thus taken, was a slight convulsive movement, which was repeated at intervals of a few seconds, and agitated the animal's body very much like a severe hiccough. This gradually increased in severity, the movements became more unsteady, the body more arched, and the limbs so stiff that the mouse stood on tiptoe. It was noted that the one idea of escaping from the trap still predominated over all else, as he continued to climb up on the bars of the cage, only to fall on his side or back at each convulsion, until no longer able to rise.

I have repeated these experiments many times with great uniformity of result. Sometimes they would dance about for half an hour, with a peculiar convulsive movement that would jerk the head and front feet from the table. Again they would fall on their side with each convulsion and regain their feet immediately only to repeat the same movement. With cats and dogs the result was somewhat different. A drachm under the skin of a cat caused such profound insensibility that she was supposed to be dead, and thrown away, but it seems that only one of the reputed nine lives of the animal had been reached, as the next day she turned up none the worse for the experiment. A full-grown dog was paralyzed in his hind legs by a similar dose hypodermically over the loins, but it recovered. Many other experiments might be adduced, but I will not trespass on your time. There is one other property

possessed by this drug that is worthy of mention,—it is a germicide and anti-ferment of no mean quality. In some clumsy experiments made by myself I have estimated its potency in this field as about one-half the strength of carbolic acid. It has long been used as a domestic remedy for the destruction of lice and other vermin."

For some years past I have had an intention of bringing before the profession reasons, rather feeble it must be admitted, for the supposition that the medicine under consideration has marked potency in a direction, so far as I know, not suspected by medical men. Up to this time the declaration on the part of standard writers that sassafras is a remedy of questionable power, and the fact that it is hawked about the streets and used freely as a tea all over the country, have caused me to refrain from bringing before a scientific body my limited experience presently to be detailed. But the recent declaration that this drug possesses toxic properties may justify me in making the following statement.

Years ago I was called to a woman among the poorer classes, of good intelligence and education, who was having a miscarriage. Upon my inquiring as to the cause of the mishap, with a prefatory reference to her poverty and already large family, she stated that she had induced the abortion herself—that she had done so on previous occasions. She had employed, she said, "what other women used," sassafras tea. She was surprised that I did not know of the property of sassafras as an oxytoxic. She spoke as if all her friends knew how to use it as an ecbolic, and she evidently looked upon it as a specific. Tea, she said, made from four or five pieces of the root, as large as the thumb and twice as long, would produce abortive effect.

A year or two later I was called to a woman two months

pregnant. For several days she had had symptoms of miscarriage of so pronounced a character that arrest of the process was doubtful. I found the patient very anxious to have a child; she disclaimed the intention of inducing abortion, and to all my inquiries as to a possible cause, of the hæmorrhage she gave answers which left me no further question except this: "Have you been drinking sassafras tea?" Surprised, she replied that for a week past she had used it at breakfast and supper. The proper remedies for her condition were prescribed, the possibly offending tea left off, and in twenty-four hours all was quiet in utero.

Farther than this my experience with sassafras as a possible abortifacient does not extend; possibly some one present can supplement my remarks with knowledge or experience of his own.

A study of the toxic effects of sassafras as reported by Dr. Hill, and here suggested, would seem to show a triple resemblance to three familiar articles, opium, strychnine and ergot.

In its action as a narcotic and sudorific it resembles opium.

In its property of inducing tetanic and clonic spasms, followed by paralysis, it is similar to strychnine.

In its power hinted at of exciting the uterus, it may be likened to ergot.

It may be of interest here to call attention to the fact that the first reference to the use of ergot as an ecbolic was made by Stearns in 1807, whereas it had been used by midwives certainly as early as 1688, and probably very much earlier.

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OBSERVATIONS ON SPIRITUALISM AND HYPNOTISM.

By G. C. PAOLI, M. D., *Chicago, Emeritus-Professor Woman's Medical College.*

[Read before the Chicago Medical Society.]

We live in a progressive period, in a time remarkable for new scientific discoveries, new mechanical inventions, new philosophical theories. Many natural phenomena which formerly were considered mysterious, can now be explained on scientific principles. We are no longer satisfied with effects, we must examine into causes, and the deeper we investigate, the less mysterious do our surroundings appear, and we discover that our planet, and all that on it, moves, is governed by immutable natural law, simple, easily understood, for, as a Swedish poet has beautifully said, "All things high and holy, both in science and poetry, are so simple that a child can understand them." In former times thunder and lightning were supposed to be caused by the meeting of a warm and cold cloud, but we have since learned that this phenomena is caused by electricity. So spirit-rappings were believed to be the medium of communication with the spirit world, but calm, thorough investigations have convinced us that such communications only occur at the meetings of a rogue and a simpleton. Superstition has always held a strong hold on the mind, and even the powerful light of science has not yet dispelled it away from civilized lands, although its forms change with changing times and circumstances. In ancient times the priests determined the future by the flights of birds, the interpretation of dreams, etc., and oracles and astrology fostered superstition, and the priesthood never lost an opportunity to profit by the eager desire of mankind to penetrate the veil that concealed the future. This kind of superstition disappeared before the light of progress, but another kind of prophets arose, who

foretold the future by cards, lines in the hand, etc. But these were not satisfactory to the thinking mind; little by little this art fell into disrepute, though there are still at this day too many who believe in like arts of the fortune-tellers. In our days a new superstition has arisen, called Spiritualism, which has now so many believers that they too form a new religious sect, whose members may sit around a table, and call up good and evil spirits at will. When spirit-rappings were first spoken of in this country there was a diversity of opinion as to how it was done, some being unwilling to believe that the raps were produced by spirits, while others believed them to be a sort of magnetic or electric operation, intended to deceive people and rob them of their money. The first who practiced these knockings, called themselves spiritual mediums, were the Fox girls of Rochester, N. Y., who made a very lucrative business of it. Some thought the raps were produced by the friction of the fingers, other that they were the results of new chemical processes. But on closer examination none of these suppositions were satisfactory, but what appeared to be a mystery proved to be in reality but as base a deception as ever has been perpetrated in a civilized land, a superstition which is a disgrace to the 19th century; resembling the Salem witchcraft and quite as injurious in its effects upon the community. Let us first examine into the causes which actuate people to impose upon the confidence of their fellow men. Some are actuated by a love of gain, others of notoriety. A third class, though undoubtedly honest in their belief, are of nervous temperament, vivid imagination, exceedingly superstitious, and easily carried away by every new issue, and particularly ready to be influenced by every thing that is beyond their comprehension. Having investigated the subject thoroughly, I will, as concisely as possible, give the result of my investiga-

tions. At an exhibition given by one of the powerful mediums, who claims to be able to move tables and other furniture by laying on of hands, I discovered that the wonder was wrought by muscular power alone. The medium in this case was a strong, muscular young woman, who, to the astonishment of the company assembled to witness her performances, pushed not only chairs before her, but the persons also who laid their hands upon them. Watching them closely, I observed that they did not at all oppose her strength, but merely kept their hands on the object while she pushed them along without their noticing it I determined to try what effect it would have to oppose my strength directly to hers. The consequence was that she could neither move the table nor the persons whose hands were on it, which created no little merriment amongst the spectators, and surprise and chagrin to the medium. She exerted herself to push the table along till great drops of perspiration rolled down her face, and after trying in vain, she finally gave up in despair.

Others, calling themselves writing-mediums, claim to be able to receive and write down communications from departed spirits. After calling up the spirit from whom the communication is desired, the hands of the medium are placed on a little table, which is tipped or rapped on, in response to the question, Is their a spirit present? and the medium is prepared with writing materials to take down the communication, and becomes very nervous, the hands tremble, unsuccessful attempts are made to write, till finally their comes a vague, unsatisfactory answer, often very far from the desired reply. For instance, if I ask for the name of one of my deceased parents, the medium writes your mother.

If I persist in asking for the name, the medium writes below that, I am the spirit of your mother, or some equally

vague reply, which is very unsatisfactory to me, but perfectly so to those who are inclined to the belief, and have no doubts of the medium's truthfulness. If I still insist on a more satisfactory answer, the medium will write, "You are faithless and unbelieving," or, "Mind your own business," or something similar, whereupon the medium or some believer will say, "There is an evil spirit present which is disturbing the communication from the departed friend." In other words, when the good spirit is fairly cornered, the discomfiture is laid to the interference of the evil one, thus leading the inquisitive mind to another subject till he is prepared for other communications, which, from the medium's knowledge of his history and relations may be correct; then we are informed that the evil spirit is no longer present. When a correct answer is given the believers seize and enlarge upon it, but never mention when mistakes are made. I have witnessed many of these manifestations and they all remind me of the ceremonies of the Egyptians, who worshiped various animals, particularly the ox. When they desired information concerning the future they consulted this animal and accepted the movements of his head or tail as decisive answers to their questions. In ancient times the priests were physicians, the temples were the dispensaries; the legends of the saints, the history of witchcraft, charms, amulets and relics, all taught that all kinds of diseases were cured by their magic means. But although spiritualism has arisen in our times, the tricks of those who have imposed upon the public have been exposed by so many of the most renowned mediums, such as the Davenport Brothers and others, that its believers are now steadily decreasing. Hypnotism, which is derived from a Greek word signifying sleep, and is usually known as mesmerism. One century ago Dr. Mesmer imposed on the public in France with a power which

he called animal magnetism, by which he pretended to cure diseases, but after thorough investigation by several scientific men, it was pronounced a fallacy and an imposition. After residing in Paris sometime he gradually lost the esteem and confidence of the public and returned to Switzerland to enjoy the large sum of money he had accumulated in France, but never after his return to his native land did he pretend to cure diseases with animal magnetism or so called mesmerism. Later, Dr. Beard, of England, who was by no means a pretender, but rather an enquirer after truth, experimented with the magnet in o-der to see whether it had the power as many supposed. And instead of using the magnet, he often took a piece of wood instead, and the process whereby he succeeded in producing sleep was simply to cause the person under control to fix the eyes steadily on a certain object; this he called Hypnotism, or Sleep.

During my residence in Stockholm, the capital of Sweden, I had an excellent opportunity to become thoroughly informed on all the phenomena of hypnotism. A Swedish general, who had served in the Turkish military service and had been honored with the title of Pasha, returned to his native country financially destitute. Trying to do something for his support, he applied himself to making experiments in Hypnotism. I was invited not only to see but to observe in detail the subjects he practiced on. The individuals he influenced were generally extremely nervous young subjects, and in many cases he failed. When he addressed them he generally did so in a commanding or authoritative tone. When any presented themselves who had wills of their own, he never succeeded. During the operation he always requested all to fix their gaze upon his eyes. I was satisfied from observation that some of the faculties of the mind were suspended for a few minutes, and the individuals he experimented on were

weak-minded and credulous. A healthy and sound mind is characterized by the proper balance of all mental faculties in the same manner that a healthy body is dependent on the proper action of all the nerves. There are mental illusions and sensorial illusions caused by predominant ideas and corrected by proper reasoning. As an instance of a false impression I will relate a case taken from an English medical journal, namely: A lady in England who one summer day enjoyed a sleep in her garden, dreamed that a grass snake had entered her bowels, after which she lived in the hallucination that she felt a strange motion, which she claimed was produced by the snake. She went to several physicians to obtain medical aid which would destroy the animal, but all in vain. In the meantime a physician declared that her diagnosis was correct, and he produced a small, innocent snake, which he had concealed, and during his examination he pretended to extract the animal, and by showing it to her she was perfectly cured, and complained only of the other doctors' ignorance. To the reflecting mind it seems that these abnormal ideas are like all religions with their gods, their demigods, their prophets and their saints, which were created by the credulous fancy of men who had not attained to the full development and possession of their intellectual faculties. Still, with all the ignorance and superstition which surrounds us, the greatest science of the day, namely, evolution, has done more for the intellectual development of the world than anything else. Such illustrious men as Huxley, Darwin, Haeckel and Lyell have not labored in vain. Their first attempts were ridiculed and despised by the orthodoxy, but their investigations stand to day as a mathematical fact, and will in the end unite the people of the world by grander, nobler principles, namely, a general scientific education, self-sacrifices and devotion to humanity.

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SUPPLEMENTAL REPORT OF INTUBATION OF THE LARYNX.

By F. E. WAHNAM, M. D. *Professor of Diseases of Children, College of Physicians and Surgeons, Chicago.*

In the November number of the JOURNAL AND EXAMINER there appeared a report by me of five cases of true croup treated by intubation, since which time six cases more have come under my care.

CASE VI.—Through the courtesy of Drs. Dahlberg and Appleby I was called November 3d to see a little patient, aged twenty months, suffering from pseudo-membranous laryngitis. The child has been sick for three or four days and now was in imminent danger of suffocation. Tracheotomy had been proposed by the attending physicians but refused by the parents, and intubation was the only resort. Assisted by Drs. Dahlberg, Appleby and Helm the operation was performed quickly, and without the least difficulty. The distressing symptoms were relieved as by magic, and the child at once passed into a quiet, refreshing sleep. The little patient took nourishment well and appeared comfortable. On the fourth day the tube was removed with some difficulty. It was held so closely by the chink of the glottis, that it was grasped with difficulty by the extracting instruments. After three attempts, ether was given the child, when it was immediately removed. The patient did well for two days, when increasing dyspnœa indicated a re-formation of the membrane. On the third day it became necessary to re-introduce the tube to prevent suffocation. Considerable muco-purulent matter and false membrane were expelled as the tube was introduced. Again the violent symptoms were overcome. The child wore the tube for two days, when it was again removed, this time at the first attempt.

The respiration continued a little noisy and slightly embar-

rassed for two or three days, but it was unnecessary to re-introduce the tube and the child made a good recovery.

This is the youngest child that has yet been saved by intubation.

CASE VII —November 9th I was called to see a little girl between four and five years of age, suffering from profound constitutional diphtheria. The child had been sick for five or six days, when the larynx became involved and it was evident that the child must soon die from suffocation unless relieved. Assisted by Dr. Bosworth and Prof. Nelson, intubation was satisfactorily performed and the suffering at once relieved. The child, however, died forty-eight hours later from the profound diphtheritic infection. The tube in this case did all that was expected, and the child died easily.

CASE VIII.—November 13th I was called by Dr. Kossakowski to tube a little child aged two years and two months, suffering from membranous laryngitis. Assisted by Dr. Kossakowski, while the father held the child in his lap, intubation was quickly performed. As the patient lived a long distance from me, a somewhat larger tube than was appropriate for the age, was introduced in order that it would surely be retained.

On the fourth day it was removed, but as it was impossible for the child to yet carry on respiration the smaller tube was introduced, fearing that possibly ulceration might occur from the pressure of the larger tube. The next day the tube was ejected and I was summoned in great haste. The child could have lived but a few hours longer. The dyspnœa was extreme. The larger tube was re-introduced and again death was averted. On the ninth day the tube was again removed, but it was still impossible for the child to live without it. As the tube was re-introduced large quantities to mucus, muco-

purulent matter and some shreds of false membrane were expelled. It is now twelve days since intubation was first performed upon the child. As it is in good condition, eating rye-bread, meat and cookies without difficulty, we certainly predict recovery. The tube will be removed to-morrow, when it is confidently expected that it will no longer be needed.

CASE IX.—November 16th I was again called by Dr. Kossakowski to perform intubation upon a little child of three years. The child was semi-comatose and it seemed hopeless to make the attempt. The child, however, revived after the operation, and the next morning took breakfast with the family at the table. The child died forty-eight hours after the operation, from extension of the membrane into the bronchial tubes.

CASE X.—November 20th I was called by Professors Casselberry and Hatfield to perform intubation upon a child five years old. The patient had been sick eight days, and twice the membrane had re-formed after being ejected. There was evidence of extensive exudation into the bronchial tubes, and it was feared that intubation would give no relief. However, large quantities of mucus, muco-purulent matter and broken down membrane were expelled, when the tube was introduced and the urgent dyspnœa greatly relieved.

The child, however, died about fifty hours after the operation, from membranous bronchitis and inflammation of left lung.

CASE XI.—November 21st I was called to perform intubation upon a little boy five years old, a patient of Dr. Valin. The child had suffered from a severe attack of pharyngeal diphtheria, as had two or three other members of the family. There had been extension of the disease into the larynx. and at this time the child was in the agonies of slow strangulation. All hope had been abandoned, but intubation was given a trial. With the assistance of the father and Dr. Valin the tube was in-

troduced without difficulty, and with the usual result of immediately relieving the violent symptoms. The child is still wearing the tube comfortably. This is the fourth day, and the pulse is now 100, temperature 100, respiration 24, and taking nourishment well. It is very likely that recovery will be the happy result in this case.

Of these eleven cases there have been two complete recoveries, and if cases eight and eleven terminate favorably, as now seems more than likely, we shall have 36 per cent. cured by intubation, a result far better than we get from tracheotomy in Chicago. It must be remembered that seven of these cases with two recoveries were but three years of age or under, a period in which tracheotomy is rarely successful.

November 27, 1885.—Cases eight and eleven are doing well without the tube, and convalescence is assured.

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A REPORT OF TWO HUNDRED CASES OF TONSILITIS.

By J. M. G. CARTER, M. A., M. D., PH. B., President of the Lake County Medical Society, Waukegan, Illinois.

(Read before the Chicago Medical Society, Nov. 16, 1885.)

On the permeable, sandy shore of Lake Michigan, with a prevailing northwest wind for a great part of the year, in connection with the natural humidity of the atmosphere near so large a body of water, we would expect to meet with a large number of cases of throat and chest-diseases. It was under such circumstances that the cases occurred, which I desire to report briefly on this occasion. For the purpose of getting a better understanding, possibly, of the relation existing between tonsilitis, diphtheria, rubeola, rötheln, and scarlatina, it may be well to mention the occurrence of these diseases

in the order of their sequence, during the time which is represented by the two hundred cases of tonsilitis that are here reported.

These cases occurred during the last two years. In the fall and early winter of 1883, I had some forty cases of scarlatina. In the months of 1884 the scarlet-fever epidemic subsided, and immediately succeeding it came an epidemic of tonsilitis. Following that, in the summer, we had some cases of rubeola. The measles subsided by fall, and again there were many cases of tonsilitis, and although there were a few cases of mild scarlet-fever through the winter of 1884–85, there were many more of sore-throat. During the spring and summer of 1885 we had an epidemic of rötheln.

During the epidemic, or rather endemic of tonsilitis following the epidemic of scarlet-fever, I treated within the months of March, April and May, about ninety cases of this disease of the throat. During the same months of 1885 I treated sixty cases. The others were somewhat sporadic, and distributed throughout the remaining months of the years 1884 and 1885.

The disease is marked at the beginning by chilliness; aching in the limbs, back of the neck and head; nausea; a feeling of stiffness in the throat. The throat and tonsils are red and the tonsils swollen; and the glands at the angle of the jaw are usually swollen and tender. In 75 per cent. of the cases, on the second day, there are ulcerated patches on the tonsils, and in 5 per cent. a tendency to the formation of a diphtheritic membrane. In 20 per cent. of these cases there are no patches on membranes. The beginning-symptoms are the same in all, and ordinary cases extend over a period of from three to five days,—usually beginning to grow better on the third day. Five cases were sick as long as two weeks;

three cases developed into quinsy, and I opened the tonsilar abscess; one case had quinsy and diphtheritic deposits. Two cases had trouble with the glands—one with the sub-maxillary and the other with those of the neck, both on the left side. In both cases it was necessary to lance the abscess. In two cases the swelling of the tonsils was very rapid and the pain of swallowing excruciating. The pulse was usually 120, and temperature 104° in adults. In children, the pulse ranged from 120 to 160, the temperature being the same as in adults. As the swelling of the tonsils began to subside, the fever began to abate. One other case I will mention, because of its close apparent relation to scarlet fever. A young Miss of fourteen was taken with the symptoms described above, the tonsils being very large. There being some scarlet fever about, we were anxious and examined and watched for development of the disease. She recovered in five days, but manifested no other than the symptoms of tonsilitis. Five days later I was called to see one of the children in the same family, and discovered at once a case of scarlet fever. Four of the children had the disease in the next ten days, three of them being malignant cases, of whom two died. Of this family the only child that did not have scarlet fever had a protracted siege of typhoid fever, three months later. Perhaps 25 per cent. of the cases I have reported were left with chronically enlarged tonsils. During the time of the occurrence of these cases, I treated but six cases of diphtheria, and they were not severe. Of the two hundred cases all recovered.

The treatment in these cases varied very little in most cases. It consisted mainly of aconite and belladonna, with, occasionally, chlorate of potassa. Sometimes, especially if there was much disturbance of the stomach, I added gelsemium. This was used internally, usually in small doses, every 30 or

60 minutes. In adults and children old enough to gargle or use a gargle as a throat-bath, I employed local treatment. I have used several gargles—alcohol and water, alcohol and chlorate of potash, water and chlorate of potash, hot water, ice water, salt and vinegar, salt and water, according to circumstances and the condition of the patient. Ordinarily I prefer alcohol and chlorate of potass. where the patient can use a gargle. Excellent external applications are mustard, camphor, kerosene, alcohol, red and black pepper.

In some cases of rapid swelling and intense pain, I secured the quickest results from steam-atomization, using carbolic acid and chlorate of potass. I have used the steam from hot water in many cases with benefit. I was called to a gentleman who was subject to quinsy. He said that he should go through the full course of the disease, he knew, for he had never succeeded in having it checked. I gave him one drop of tincture of aconite and tincture of gelsemium, each, and four drops of tincture of belladonna every hour. I also directed the use of steam, and an alum gargle. The throat grew better, and he recovered without going through any "course" of disease. He has had one similar attack since, and by treating him in the same way we had the same result.

The tincture of the chloride of iron I employed in a few cases. In one case I employed the compound of tincture of iron, carbolic acid, glycerine, chlorate of potash and water, and with no better result than I received from more palatable preparations.

The ordinary course of tonics was prescribed, in some cases, as an after treatment, but generally no tonic treatment was needed. Lactic acid, nitric acid, and hydrochloric acid were freely used in a few cases.

I will report that in the great majority of cases alcohol, chlo-

rate of potass. and water gave the most satisfactory results; while internally tincture of aconite, tincture of belladonna and tincture of gelsemium are equally beneficial.

There must be some cause for such a prevalence of this disease in any locality. There must be a cause for its prevalence at the same season of the year. It will be remembered that the greater number of these cases occurred during the months of March, April and May. In casting about for some special features, which during these months are different from, or in excess of, those of other months, we find an apparent cause in the prevailing northeast wind. During the three months named, the western shore of Lake Michigan has more days of lake-winds than of winds from any other direction. The lake-winds prevail more generally at Milwaukee than at Chicago. During the month of May, for instance, at Milwaukee the easterly winds are to the westerly as 62 to 24, while at Chicago they are as 44 to 40. In this relation, Waukegan more nearly approaches Milwaukee. We usually have an increase of the disease under discussion during the month of July, and during that month there is a preponderance of lake-winds at the points mentioned. At Chicago, the easterly winds are to the westerly as 60 to 33, while at Milwaukee they are as 48 to 37.

At Waukegan, the record for the ozone-test, last year showed that the presence of that agent was very marked during the time when tonsilitis prevailed; that is, the lake-winds seem to sustain some special relation to ozone in the atmosphere. Not having made any experiments with a view to determine this relation, I am not prepared to discuss it. During the last summer, especially in July, northeast and east winds prevailed to a greater extent than usual. Rötheln was the prevailing disease, 75 cases of which occurred in my practice. More

than 50 per cent. of these cases were accompanied with sore throat,—the symptoms being precisely the same as in simple tonsilitis. Nearly one-half of the total number of cases of rötheln had ulcerative patches on the tonsils.

Exposure to cold has not been a frequent cause of this sore-throat, for a very large proportion of my cases were parties who had not been exposed to cold; however, such exposure in some cases was known to be the exciting cause. I would mention one other point. I have noticed that rheumatic and nervous patients were not so well during these periods.

From a consideration of all these points, I have been led to suspect that the disease under discussion, like nervous disorders and rheumatism, is affected by, if not due to, the electrical condition of the atmosphere; but whether to an excess or a deficiency of electricity I have not sufficient data to determine accurately. We know this: that the disease prevails when there is a humid atmosphere, an excess of ozone, a lake-wind, and a low temperature. We know, further, that these agencies work changes in the electrical condition of the atmosphere.

A CASE OF CHRONIC SIMPLE GLAUCOMA TREATED WITH ESERINE. S. O. RICHEY, M. D., *Washington, D. C.*

[Read before the Medical Society of the District of Columbia.]

This is not written with a hope of adding anything new to the subject, nor with an intention to fully discuss the varying views of its pathology, but only to report a case, in my judgment, worthy of record, because it is one of "the type of the whole group of glaucomatous diseases."

On January 21, 1885, I examined Mrs. F., aged 37 years,

whose left eye was blind from absolute glaucoma; the vision of her right eye was $\frac{20}{100}$, and much blurred. She knows the left eye to have been blind for seven years; the right has been affected for that length of time, but she does not know whether it has been diseased for a longer time than seven years or not. When she was about eighteen years old she noticed the halo, and had flashes of light, but these do not now continue. The right eye has been sensitive to light for seven years, but she has never had any pain in either of her eyes.

Just before Christmas she sewed quite a good deal, using her mother's glasses, before which time she had not used her eyes for a year at close work. "The room seems full of smoke," as she looks about it now. She was frightened into consulting a physician by finding that, although she could see the form, she could not distinguish the face of her pastor in the pulpit a few days since.

A lens serves only to interrupt the vision of the right eye. The discs are well cupped with sharp outlines. The excavation is deeper in the left eye, and the nerve is atrophied. Tension + 3; both feel like small marbles; the media are clear, the pupils half-dilated and regular; the anterior chambers are shallow, and the corneæ anæsthetic. The field of vision is limited to the nasal half.

Her general health is bad; her digestion is poor, associated with great mental depression. The idea of an operation creates dread, and the treatment adopted is sulphate of eserine (gr. $\frac{1}{4}$ to f $\frac{\mathfrak{z}}{3}$i), applied twice a day, with dry cups to the temples.

January 25th. Vision of right eye, $\frac{20}{80}$; tension + 2. There is no very marked change in the size of the pupils, nor in the depth of the anterior chambers. Liquor potassæ arsenitis in gtt. ii doses was given *ter in die*, to correct fermentation,

and kal. iod. after meals, to hasten tissue change, are added.

January 29th, the pupils are normal in size, but still sluggish, due now probably to the eserine. Vision, $\frac{20}{40}$. The improvement constant and gradual until March 28th, when vision $\frac{20}{18}$; the tension normal. The field is not altered.

November 11th, 1885, eleven months after the first interview, the field is not changed; the tension is normal; vision, in the right eye, is slightly less than normal, and her general condition is much improved. She has been advised to persist, for a time, in the occasional use of the myotic, because the condition is a very chronic one; that she must avoid mental excitement, and preserve her general bodily health in the hope that this interruption to the progress of the disease may be permanent. Iodide of potash was exhibited with a view to breaking up any adhesions of the iris that might exist, upon the basis of its action in the treatment of posterior synechia. This also has been continued at intervals.

The special features of the case are: the age of the patient when first affected (eighteen years); the great amount of tension tolerated for so long a time, and the degree of vision recovered without operation. There was no hypermetropia, and the necessity for convex lenses at her age may be explained by the probability of the suspensory ligament being put so much on a stretch by pressure that accommodation was interfered with, or that the retina, being obtunded by pressure, required larger images than usual.

Mr. Henry Powers * says: "Eserine is a valuable remedy, and he is inclined to doubt whether some of the results attributed to sclerotomy might not really have been due to the use of eserine. If the pupil responded to eserine, he would certainly continue its use and not operate at that time."

* O. Review, 1882, p. 262.

This affection, presenting itself in so many ways, is least hopeful in the chronic simple form, which rarely announces its presence before the age of fifty years, and makes slow, insidious progress, generally without any inflammation, as in this case, and commonly proves fatal to vision, whatever the treatment. Though many expedients are helpful, it is very intractable.

The methods of relief are surgical, except the use of myotics; iridectomy, sclerotomy, and stretching the supra-trochlear nerve,—the last suggested by Badal, of Bordeaux, in 1882,—each founded upon a rational theory of the pathogeny of the affection.

Increase of tension is pathognomonic of the disease, and whether this is due to hypersecretion or an impeded outflow of the intra-ocular fluids, opinions differ. Priestly Smith* says: "It is certain that glaucoma is essentially due to pressure; that it is cured by reduction of tension, and that this reduction is due to restored filtration."

It was upon this theory of the nature of glaucoma that Græfe performed iridectomy, to relieve swelling of the ciliary folds, and the adhesions of the iris at the iritic angle, which obstruct the entrance of the intra-ocular fluids to the canal of Schlemm, though Wolfe† claims the benefit from iridectomy to be due to the removal of a section of the diseased nerves, upon the theory of nutritive changes in the nerve-centers.

The cupping of the optic disc is held by Mooren‡ to be due to changes external to the eye, and he is convinced that "The presence or absence, and breadth and depth of the excavation are not dependent in any way on the degree of increase of in-

* Ophthalmic Review; 1882, p. 261.

† Wolfe, On Diseases and Injuries to the Eye.

‡ Archiv. Ophth., March, 1884.

tra-ocular pressure; . . . . that even the most brilliant therapeutic results will not alter the fact that in glaucomatous excavation of the optic nerve, or in the excavation of glaucoma simplex, with or without inflammatory symptoms, we have to deal with some anomaly of nutrition of the optic nerve."

All observers agree that there is no fixed relation between intra-ocular tension and the disc-cupping, though when there has been great tension with little or no cupping, the fact has been attributed to the greater power of resistance of the optic papilla.

Gowers* records the fact that "Glaucoma is sometimes observed in cases in which there was long standing liability to unilateral neuralgia, . . . that optic atrophy has resulted from the same cause, and that irritation of the fifth nerve may increase intra-ocular tension." Douders† refers to the fifth nerve as controlling intra-ocular secretions, and Grünhagen and Hippel‡ found that irritation of the trigeminus produced increased intra-ocular pressure.

From the foregoing it may be seen that there are at least two methods of accounting for glaucoma: the pressure theory and that of a neurosis. These are not necessarily antagonistic, for each may explain one stage of the same attack. Each attack must have an initial stage, as, in secondary glaucoma, a dislocated lens, or an intra-ocular hemorrhage; so, in primary simple glaucoma, some disturbance of the sympathetic system may interfere with the balance existing between the secretion and filtration of intra-ocular fluids, and by increasing tension, inaugurate a "vicious circle."

Iridectomy is the most reliable of all the measures adopted

* Medical Ophthalmoscopy, p, 172.

† Klin. Monatsblatt fur Augenheilkunde, 1884, p. 434.

‡ Arch. fur Ophthal. B. xiv. 3, p. 219.

in glaucoma, though it sometimes fails, and in some cases the probability of hemorrhage forbids it. Its influence may be explained in accordance with either theory, for it acts in both ways, relieving tension, and by removing a section of the nerve, but Mooren thinks it "useless in all cases of glaucomatous disease which do not originate in the eye but in the centre of nutrition of the optic nerve." Badal's operation of stretching the supra-trochlear nerve is based upon the theory of a neurosis, and has been efficient in some cases—even in some which have defied other efforts at relief. It is, however, not reliable, and should be only a last resort.

Sclerotomy reduces tension by opening a way between the aqueous chamber and the sub-conjunctival space, producing an anterior staphyloma and establishing permanent drainage.

It is likely to be followed by distortion of images in consequence of the staphyloma. The necessity of using a myotic diminishes the importance of the procedure, and the objection has been made that it excites sympathetic inflammation. As the incision must be made within the sclerotic, it is probable the ciliary region has been wounded in such instances.

Priestly Smith claims the essential part of this operation and iridectomy to be the same, only the incision is more favorably made in sclerotomy; that when the incision is made as peripheral in iridectomy, it is the more reliable operation, and the effect is more permanent, although it is not so safe in cases where there is immediate danger of hemorrhage. Argyle Robertson's operation of trephining the cornea has been successful in a few cases, but has not at any time met with general adoption. Paracentesis is a measure to gain time, or to discover the amount of vision that may be recovered by an iridectomy in acute glaucoma.

Eserine, it is said, gives its best results in acute primary

glaucoma, and may entirely relieve the eye, but while it sometimes improves the condition in simple chronic glaucoma, this improvement will probably not be permanent.

Williams,* of Boston, has not an impression favorable to the use of eserine in glaucoma, and doubts its efficiency in this affection in the hands of others. This view is one for which it is difficult to account, as the drug has unquestionable powers to reduce tension.

Snell† believes that eserine not only improves vision but arrests the progress of chronic simple glaucoma.

I have not found it produce follicular conjunctivitis, to which Wecker refers, because, I think, I have not been accustomed to use it in so strong solution. The milder solutions have in my hands been as useful as the strong ones and without any misadventure, though they must be used more frequently. The frequency of application of a mild preparation lessens the tendency to spasmodic myosis. The action is more gentle and less likely to produce congestion of either the conjunctiva or the iris. Eserine is preferable to pilocarpine, because this disposition to spasm may be controlled, and it maintains myosis for a longer period.

BLINDNESS FOLLOWING HEMORRHAGE.

By BOERNE BETTMAN, M. D.

(Read before the Chicago Society of Ophthalmology and Otology.)

Cases of amaurosis following hemorrhage, although not infrequent, are, owing to the darkness enshrouding their pathology, full of interest. The two cases which I will report to the Society this evening offer certain symptoms which point

* Williams, Diagnosis and Treatment of Diseases of the Eye. 1881.

† On Eserine and Pilocarpine in Glaucoma, and Eserine in Ocular Neuralgia.

apparently to a common cause, namely, intracranial hemorrhage with subsequent alterations of the optic nerves.

The clinical history of the first case was extracted from the books of the Eye Clinic of Heidelberg, during my assistantship. It reads as follows:

Margaretha Feth: Aet 26, was admitted into the clinic, 1879. Patient is of healthy parentage, her mother is a hale and hearty woman of 79 years. Her father, who died three years ago of heart disease, reached the same age. Up to her fifth year she had repeated attacks of convulsions; several brothers and sisters, seven in all, died a few months after birth from the effects of similar spasms. Miss F. was otherwise a healthy, well-nourished child. Three years ago, while descending the cellar stairs, she slipped, broke and dislocated her left femur. After fifty-five days' confinement in the hospital, under the care of Prof. Nussbaum, she was discharged with a shortened limb.

On the 17th of May, 1879, while at home, she suddenly experienced a severe pain in the left side of her head, accompanied by dizziness and severe spells of vomiting. A physician was hastily summoned, he prescribed a number of powders which she could not retain in the stomach. She was unable to sleep that night; the headache continued during the next day and night, also the vomiting at frequent intervals. Her menstrual flow, which lasted from the 13th to the 18th, was not as profuse as on former occasions. On the 21st, whilst in bed, another sudden attack of dizziness resulted in unconsciousness. In this condition she remained two days. During the morning of the 22d her mother observed a large quantity of dark blood well from her mouth. The hemorrhage, according to the parent's statement, lasted fully ten minutes. The blood was not coughed up, but simply flowed from the mouth

as a dark, foamy substance, mixed with a greenish mass, undoubtedly secretions from the stomach. She remained unconscious or asleep until the next morning; on awakening, all was dark around her. She was unable to see her mother standing before her with a glass of milk in her hand. Quite good sight returned to the right eye during the course of the day. A few days later, while on her way to Mannheim, dizziness again supervened, and she fell unconscious to the ground. In this state she was removed to the hospital. She regained her senses two days later. With the right eye she could barely distinguish the faces of friends close to her bed. Vision gradually diminished. On the day of admission into the clinic there was complete amaurosis of both eyes. The pupils were dilated ad maximum, the irides did not respond to light. An ophthalmoscopic examination showed decided atrophy of both discs, with thin, thread-like vessels, on both sides of which were seen broad opaque strips (perivasculitis) extending towards the periphery.

The patient remained in the hospital a long time; treatment of all varieties proved useless. Before entering the house she had taken large doses of iodide of potash, and received numerous injections of strychnine.

February 18, 1885. Dr. Hessert kindly sent me for examination a little patient, George Dohl, aged 3 years. The parents informed me that the child had fallen ten days previously against the edge of a chair, striking with the upper teeth. The boy sustained no injury except a loosening of the upper incisors. The gum bled profusely, the blood trickling down between the teeth. After all house remedies had been tried, and failed to still the hemorrhage, Dr. Hessert was called in. He succeeded in arresting the bleeding on the third day, by making digital compression, which the parents continued some

time in accordance with his instructions. The following, the fourth day, was marked by long-continued, violent convulsions, lasting fully forty-eight hours. Blindness in both eyes was noticed during an interim of the spasms. The boy presented the following appearance when brought to my office: Pale, weak-looking child, pupils of both eyes dilated, reaction to light good and quite prompt. Media of both eyes clear. Papillæ very anæmic, almost perfectly white. Caliber of arteries diminished, veins somewhat dilated. Vision, O.

The child was too young to permit me to test the sensibility of its retinæ to light. My prognosis was unfavorable, still I took particular pains to call the parents' attention to one favorable feature of the case, namely, the prompt reaction of the irides, which I interpreted as indicative of a partial restoration of vision. Nourishing food, fresh air and other tonics were prescribed. Stimulants of all kinds were prohibited. I subsequently learned from Dr. Hessert that the vision had improved quite materially, sufficient to enable the child to roam about the house without danger of falling over or knocking against the various pieces of furniture. He could also distinguish smaller objects, as for instance, a knife or key, when thrown upon the floor. The child unfortunately succumbed to a second attack of convulsions, occurring eight weeks after the first.

The clinical histories of these cases appear so clear that but little difficulty will be experienced in assigning them to that category of cases mentioned in the introductory remarks. Several theories have been advanced to explain the relationship between these hemorrhages and amaurosis. The oldest and by far the most plausible theory is the one apparently adhered to by that critical observer, Alfred von Graefe. He relates two cases of sudden blindness following hæmatemesis.

After a thorough analysis he expresses his inabiliiy to attribute the amaurosis to any direct cause, but mentions later on (in another paper) that in all probabilities irritative changes in the optic nerve, behind the eye-ball, may be regarded as the exciting influence.*

The clinical history of his first case, that of Charles R., a farmer, aged 43 years, shows that a severe spell of vomiting (one-half quart blood), which had been preceded by eight to ten similar attacks, was followed by severe palpitation of the heart and continuous headache. On the evening of the second day following this severe hematemesis, and when he had recovered from the weakness induced by the loss of blood, he noticed a cloud was before his eyes, which developed into complete blindness six hours later. Since then his condition has undergone no material change.

Graefe attributed the haematemesis to an ulcer of the stomach.

In the second case a hemorrhage from stomach and bowels was followed two days later by dimness of sight, preceded by severe headache. The obscuration of sight increased gradually, terminating in amaurosis by the end of the second day. Graefe also states that on two rapidly following occasions, occurring soon after power of sight had been annulled, the left hand became partially paralyzed, the mouth was distorted, enunciation became difficult and indistinct.

Samelsohn† mentions two cases of amaurosis, one one-sided, which can be clearly traced to a peripheric lesion.

In two other cases recorded by him the loss of vision cannot be accounted for in the above manner, neither can it be ascribed to a central cause, the common factor of both hæ

*Graefe's Arch. Vol. xii., p. 149.

†Gr. Archiv. Vol. xviii., p. 225.

matemesis and amaurosis. He therefore finds refuge in another theory which he describes at great length. He is of the opinion that the pressure exerted by the blood in the brain is counterbalanced by that of the lymph column. A diminution in quantity of one fluid will be followed by an excess of the other. The result of this deficiency on the part of one and a superabundance of the other, will result in imperfect nutrition, pressure and inflammation. Thus it is supposed that an excessive hemorrhage from the stomach or rectum will deplete the system to a certain extent, and produce a cerebral anaemia. As the blood leaves the brain the lymph rushes in to produce the dire catastrophy. Dr. Samelsohn supports this hypothesis on experiments made by H. Gaethgans. This observer found that a congestion of the brain is followed by increased flow of lymph from that organ. The above explanation may be adequate to account for amaurosis of both eyes following hemorrhage, but certainly is not tenable when applied to one-sided amaurosis.

Finkensteiner's* case developed complete and gradual amaurosis following extensive gastric hemorrhage induced by ulceration of the stomach. The author hints at a possible cerebral connection between the necrotic process of the mucous membrane and the disturbance of the visual tract.

Another method (which was formerly regarded with favor) of interpreting the amaurosis, was to ascribe it to general anemia. Were this so, the archives of medicine in the Pre-Esmarck period would have been replete with instances of this kind. The most striking proof of the inconsistency of such a theory is one-sided amaurosis and the continuance of blindness in cases where the hemorrhage produced little if any anaemia. No doubt many factors come into play, and are capable of

*Gr. Archiv. Vol. viii., p. 209.

producing amaurosis, as a resultant of hemorrhage. But it appears to me that one and an almost constant occurrence in connection with the subject in question, has not received the attention it deserves, in fact it is hardly alluded to in the papers relating to this affection. It is a well-known fact that hemorrhage in all parts of the body frequently occur in debilitated subjects; that, owing either to some change in the walls of the blood vessels, or some anomaly of the circulation, hemorrhages, either by diapadasis or rhexis, are prone to occur in such individuals. I have frequently observed extravasations in the retina, in cases of pernicious anæmia,* and Litten† has recorded many such occurrences in the cases of anæmic individuals generally.

Exertions of all kinds naturally form an incentive to rupture of weakened blood-vessels, even those in a normal condition frequently give way, as the result of either increased or diminished pressure of the blood column. How often do we observe subconjunctional ecchymosis directly attributable to excessive spells of coughing or vomiting. Numerous cases have been reported of hemorrhages into the retinæ‡ vitreous, caused by bodily strain.

In our own cases severe attacks of vomiting and spasms, lasting in one instance several days, in the other, forty-eight hours, were undoubtedly the direct cause of the amaurosis. The sudden pain in the head experienced by the first case, followed on two occasions by vomiting, dizziness and unconsciousness, point to an intracranial lesion. In Samelsohn's cases we note that both patients complain of headache following hæmatemesis. Graefe also calls especial attention to this

*Bettman. The Condition of the Eyes in Fatal Anæmia.

†Archives Ophth. Vol. xi, p. 1.

‡Berl. kl. Wochenschr., 2d, 20 W. 21, 1877.

symptom, and mentions in this connection two slight attacks of paralysis.

The above would tend to demonstrate that although hemorrhage from stomach and the gums may be followed by amaurosis, the bleeding from these parts should not be considered as the direct cause of the blindness, but rather as a symptom concurrent with intracranial changes bearing directly upon the optic tract: hemorrhage.

113 Adams street.

EDITORIAL.

THE NINTH INTERNATIONAL MEDICAL CONGRESS.

So much has already been said and written regarding the next International Medical Congress, and the mistakes and misunderstandings attending its organization, that it is an unwelcome task to say more regarding it. Since, however, there appears to be much confusion of ideas, and, also, such an erroneous impression at home and abroad, of the history of the efforts at organization, it may lead to a better understanding of the case if the facts be given, *ab initio*, in chronological order.

During the annual meeting of the American Medical Association in Washington, D. C., in May, 1884, a desire was expressed that an invitation be extended to the Eighth International Medical Congress, about to assemble in Copenhagen, Denmark, to hold the next Triennial Congress in Washington, D. C. It was understood that in extending such invitation the American Medical Association was selected, because it represented, more fully than any other medical organization in the United

States, the whole medical profession of our country. For that reason the medical profession considered that its wish and its invitation would be regarded as more authoritatively expressed if the American Medical Association would consent to become sponsor for it, and to issue the invitation. The president of the Association, in his address, advised compliance with this expressed wish. Thereupon, that part of the president's address was referred to a committee, who reported as follows:

"Dr. J. S. Billings, of the Committee on International Medical Congress, presented the following: 'The committee to which was referred that part of the president's address relating to the proposed meeting of the International Medical Congress in the United States, in 1887, has the honor to report that it has conferred, so far as the limited time at its disposal would allow, with leading members of the Association, representing all parts of the country, and that the sentiment appears to be practically unanimous in favor of carrying out the suggestions made by the president.

"'The Committee accordingly respectfully submits the following resolutions with the recommendation that they be adopted by the Asssociation:

"'*Resolved*, 1. That a Committee of seven, of which Dr. Austin Flint, the President of this Association shall be a member, shall be appointed by the President.

"'2. It shall be the duty of this Committee to extend in behalf of the medical profession of the United States to the International Medical Congress, about to meet at Copenhagen, a cordial invitation to have the next International Medical Congress meet at Washington, D. C., in 1887.

"'*Resolved*, 2. That the Committee shall elect its own officers, and that, in case the invitation is accepted, it shall proceed to act as an Executive Committee, with full power to fix the time and to make all necessary and suitable arrangements for the meeting of such Congress, and to solicit funds for this purpose.

"'3. That the Committee shall have power to add to its membership; to perfect its organization, and that to meet the preliminary expenses of printing, postage, etc., the chairman of this Committee is authorized to draw upon the Treasurer of this Association for an amount not exceeding four hundred dollars

"'(Signed) "'J. S. BILLINGS,
"'L. A. SAYRE,
"'I. MINIS HAYS,
"'H. F. CAMPBELL.

"'R. W. Foster not present.'

"On motion, the report was adopted."

The committee thus appointed proceeded to Copenhagen and presented the invitation. It was considered by the Eighth Congress, and formally accepted.

After the return of the committee to the United States, preliminary arrangements were begun by the committee of invitation, that, under the resolutions above given, was made "an Executive Committee with full power to fix the time and to make all necessary and suitable arrangements for the meeting of such congress, and to solicit funds for this purpose," and, "that the committee shall have power to add to its membership, to perfect its organization."

It seems that the committee, thus made an executive committee, considered that under the resolutions which authorized its appointment full power was conferred upon it to make *all* arrangements for the congress, even to the selection of the general officers and the arranging of the different working sections, and the completion of the organization of each section. In fact, that plenary power had been conferred upon the committee by those resolutions, and that the duties of the American Medical Association, practically, ceased with the appointment of the committee, and the appropriation of funds for the specified purposes.

A large part of the American Medical Association, who

participated in the Washington meeting and voted for the resolutions, claims to have understood their import differently from the construction put upon them by the committee, which is now generally designated as "the original committee." The incompleteness of the instructions given by these resolutions, and the difference in the interpretation of them, seems to have been the starting-point of the differences which have so greatly divided the profession of our country, and caused so much misunderstanding and anxiety abroad. "The original committee" added to its number as it had been specially authorized to do, and proceeded not only "to perfect its organization," but also "to perfect" the organization of the congress.

The resolutions did not appoint the original committee to the offices of the congress, nor, on the other hand, did they say that the members of that committee should not be appointed officers of the congress. It is assumed that the members of the original committee, and those who were added to that committee, making the "General Committee," acted in accordance with what was believed to be for the best interest of the congress, although it has been charged that personal considerations had not, in some instances, been subordinated to the welfare of the congress. However, in discharging the important and difficult duty assigned the committee, it was not to be expected that it was practicable to wholly avoid mistakes, and in discharging its duties, it performed them very well, in many respects. The selections made were, in the main, men who are eminent, capable, and representative. Whilst it is claimed that mistakes were made, yet they were not such as would have had a specially unfavorable influence on the congress, except in the rules adopted regulating the American membership of the congress, which restricted the membership to delegates from organized regular medical so-

cieties and associations, "and of such persons as may be specially designated by the executive committee . . ." Such restriction had not been imposed at the meeting of a congress yet held.

Just prior to the annual meeting, in April, 1885, of the American Medical Association, in New Orleans, the Executive Committee announced the "Rules and Preliminary Organization" of the Ninth. Congress, without having reported officially to the American Medical Association the fact that it had performed the duty assigned it, by the association, of presenting the invitation, or the fact that the invitation had been accepted.

These acts of omission, and of commission, gave rise to criticism upon the course of the Executive Committee, and to charges that it had exceeded its authority. There were those who, whilst admitting that the resolutions authorized the Committee of Invitation to elect *its* own officers, and to add to *its* membership, yet claimed that in saying that "it shall proceed to act as an Executive Committee, with full power to fix the time and to make all necessary and suitable arrangements for the meeting of such congress, . . ." authority was not thereby given to it to select the officers for the congress. It was further claimed that the committee which had now become the "Executive Committee" should have reported to the American Medical Association, from which it had received its appointment and its powers, the preliminary work that had been done, in arranging for the congress during the interval between the two annual meetings of the Association, and before making a public announcement of that preliminary work. It was further claimed that when such report should be made, by the Executive Committee, it was competent for the association—the appointing power—to receive such report and to retain, or

alter, or discharge its committee, and to adopt, or modify, or reject the report of the work of its committee.

Here the second misunderstanding seems to have arisen. The Executive Committee claimed that it had not exceeded its authority, according to its understanding of the power conferred upon it by the resolutions adopted at the previous annual meeting of the association; that it had acted in good faith, and that it believed that its work had been well done, and done with an understanding, on its part, that the committee was to be continued intact, and that its work was not to be subject to revision or alteration by the association.

After discussion of these matters in the annual meeting of the American Medical Association in April, 1885, at New Orleans, when the "Original Enlarged Committee" made its report to the Association, it was

1. "*Resolved*, That the Committee appointed by this Association, to arrange for the meeting of the International Medical Congress in America, in 1887, be enlarged by the addition of thirty-eight members, one from each State and Territory, the District of Columbia, the Army, Navy and Marine Hospital service, to be appointed by the Chairman at this meeting, and that the committee, thus enlarged, shall proceed at once to review, alter and amend the motions of the present Committee as it may deem best."

(This resolution was amended by the provision, "that the members of the Committee should be selected by the respective State delegations.")

The following is a list of the Committee enlarged in accordance with the resolution as amended:

W. E. Anthony, M. D., Providence, R. I.; G. Baird, M. D., Wheeling, W. Va.; Robert Battey, M. D., Rome, Ga.; F. W. Beard, M. D., Vincennes, Ind.; J. S. Billings, M. D., U. S. Army, Washington, D. C.; J. M. Browne, M. D., U. S. Navy,

Washington, D. C.; L. P. Bush, M. D., Wilmington, Del.; H. F. Campbell, M. D., Augusta, Ga.; R. Beverly Cole, M. D., San Francisco, Cal.; E. P. Cook, M. D., Mendota, Ill.; W. C. Dabney, M. D., Charlottesville, Va.; Charles Denison, M. D., Denver, Col.; W. E. Duncan, M. D., Ellendale, Dakota Ter.; J. W. Dupree, M. D., Baton Rouge, La.; Ellsworth Eliot, M. D., New York City; G. J. Englemann, M. D., St. Louis, Mo.; N. F. Essig, M. D., Plattsburg, Mo.; Austin Flint, M. D., LL. D., New York City; E. P. Frazer, M. D., Portland, Oregon; George F. French, M. D., Minneapolis, Minn.; A. Y. P. Garnett, M. D., Washington, D. C.; S. C. Gordon, M. D., Portland, Me.; J. W. S. Gouley, M. D., New York City; F. M. Gunnell, M. D., U. S. Navy, Washington, D. C.; John B. Hamilton, M. D., U. S. Marine Hospital Service, Washington, D. C.; I. M. Hays, M. D., Philadelphia, Pa.; C. Johnston, M. D., Baltimore, Md.; George A. Ketchum. M. D., Mobile, Ala.; R. A. Kinloch, M. D., Charleston, S. C.; D. A. Linthicum, M.D., Helena, Ark.; John S. Lynch, M. D., Baltimore, Md.; J. J. McAchran, M. D., Laramie City, Wyom. Ter.; J. W. McLaughlin, M. D., Austin, Tex.; R. C. Moore, M. D., Omaha, Neb.; Robert Murray, M. D., U. S. Army, Washington, D. C.; R. D. Murray, M. D., Moultrie, Fla.; J. W. Parsons, M. D., Portsmouth, N. H.; William Pierson, M. D., Orange, N. J.; N. J. Pitman, M. D., Tarboro, N. C.; L. A. Sayre, M. D., New York City; X. C. Scott, M. D., Cleveland, O.; Nicholas Senn, M. D., Milwaukee, Wis.; John V. Shoemaker, M. D., Philadelphia, Pa.; F. L. Sim, M. D., Memphis, Tenn.; A. R. Smart, M. D., Hudson, Mich.; D. W. Stormont, M. D., Topeka, Kan.; J. M. Taylor, M. D., Corinth, Miss.; E. F. Upham, M. D., West Randolph, Vt.; W. H. Wathen, M. D., Louisville, Ky.; W. Watson, M. D., Dubuque, Iowa.; W. C. Wile, M. D., Sandy Hook, Conn.; A. H. Wilson, M. D., Boston, Mass.

At an informal meeting of the Committee, held at New Orleans during the session of the American Medical Association, in April, 1885, Dr. R. Beverly Cole, of San Francisco, Cal., was elected temporary Chairman, and Dr. John V. Shoemaker, of Philadelphia, Pa., was elected temporary Secretary.

Just before the final adjournment of the Association the following was adopted:

Resolved, That the Committee appointed in pursuance of a resolution adopted by this Association, April 30, 1885, to constitute an addition to the original Committee of seven previously appointed to invite and make arrangements for the meeting of the International Medical Congress, to be held in Washington, D. C., in 1887, be, and the said Committee is hereby, authorized and empowered to select a Chairman and a Secretary, and to fill all vacancies that may occur by death or inability to attend the Committee meetings, and to appoint the officers of the Congress.

This resolution has been construed as eliminating from the "General Committee" the President of the American Medical Association, added by vote, and, also, the members added by the "Original Committee," in accordance with the authority given it at the previous annual meeting of the Association. It is claimed that the wording of this resolution, whatever may have been its intent, is not conclusive that, by the passage of that resolution, the Association rescinded its act of a year before, when it authorized such additions to the membership of the "Original Committee." The two material points of this resolution are, that it is held by some that it left the status of the twenty-eight members added, in doubt; and that it definitely "empowered" its second "enlarged" Committee of Arrangements "to appoint the officers of the congress."

The second enlarged Committee held its first meeting at

Chicago, Ill., on June 24th and June 25th, 1885, for the purposes of organization and the transaction of the business committed to it by the American Medical Association.

In order to facilitate the holding of meetings in different sections of the country, the Committee deemed it advisable to select a Vice-Chairman, in addition to a Chairman and a Secretary.

The following named members were present at the meeting held in Chicago:

G. Baird, M. D., Wheeling, W. Va.
Robert Battey, M. D., Rome, Ga.
F. W. Beard, M. D., Vincennes, Ind.
J. S. Billings, M. D., Washington, D. C.
R. Beverly Cole, M. D., San Francisco, Cal.
E. P. Cook, M. D., Mendota, Ill.
W. E. Duncan, M. D., Ellendale, Dakota Ter.
Ellsworth Eliot, M. D., New York City.
N. F. Essig, M. D., Plattsburg, Mo.
G. F. French, M. D., Minneapolis, Minn.
A. Y. P. Garnett, M. D., Washington, D. C.
John B. Hamilton, M. D., Washington, D. C.
I. M. Hays, M. D., Philadelphia, Pa.
George A. Ketchum, M. D., Mobile, Alabama.
D. A. Linthicum, M. D., Helena, Ark.
John S. Lynch, M. D., Baltimore, Md.
J. W. McLaughlin, M. D., Austin, Texas.
X. C. Scott, M. D., Cleveland, O.
Nicholas Senn, M. D., Milwaukee, Wis.
John V. Shoemaker, M. D., Philadelphia, Pa.
F. L. Sims, M. D., Memphis, Tenn.
A. R. Smart, M. D., Hudson, Mich.
D. W. Stormont, M. D., Topeka, Kan.

E. F. Upham, M. D., West Randolph, N. Y.

W. H. Wathen, M. D., Louisville, Ky.

W. Watson, M. D., Dubuque, Iowa.

A. H. Wilson, M. D., Boston, Mass.

The resignation of Dr. Austin Flint, of New York, as a member of the Committee, was presented and accepted. Dr. J. W. S. Gouley, New York, was elected to fill the vacancy, and took his seat with the Committe.

The Committee then organized, a majority of its members being present, by the election of the following officers:

Chairman, Dr. R. Beverly Cole, San Francisco, Cal.

Vice-Chairman, Dr. John S. Lynch, Baltimore, Md.

Secretary, Dr. John V. Shoemaker, Philadelphia, Pa.

After the organization of the Committee, the number of members necessary for a quorum for future meetings was fixed at fifteen.

The following preamble and resolution were adopted, to apply to future meetings of the Committee:

"WHEREAS.—It is expedient that the meetings of this Committee shall represent, as far as practicable, the profession of all portions of our country,

"*Resolved.*—That any member of this Committee who may be unable to attend a meeting, shall be empowered to send as his proxy for the meeting any member of the American Medical Association, in good professional standing and a resident of his State or a member of his Government Department."

It was agreed that members of the Committee of Arrangements should not be elected officers of the Congress.

Under the instructions embodied in the Association's resolution, the committee proceeded to "review, alter and amend the action of the original committee of eight, by the adoption of the following general plan of organization.

1. The Congress shall be composed of members of the

regular medical profession, who shall have inscribed their names on the register, and taken out their tickets of admission.

The American members of the Congress shall consist of delegates from the American Medical Association, and the medical societies in affiliation with the American Medical Association, each of said societies being entitled to appoint one delegate for every ten of its members.

The members of all special and subordinate committees, appointed by the Committee of Arrangements, shall also be entitled to membership in the Congress, and such other scieutific men as are approved by the Executive Committee,

All societies entitled to representation are requested to elect their delegates at their last regular meeting preceding the meeting of the Congress, and to furnish the Secretary-General with a certified list of the delegates so appointed.

2. The work of the Congress shall be divided into sixteen sections, as follows, namely:

1. Medical Education, Legislation and Registration, including methods of teaching, and buildings, apparatus, etc., connected therewith.
2. Anatomy.
3. Physiology.
4. Pathology.
5. Medicine.
6. Surgery.
7. Obstetrics and Gynæcology.
8. Ophthalmology.
9. Otology.
10. Dermatology and Syphilis.
11. Laryngology.
12. Public and International Hygiene.
13. Collective Investigation, Nomenclature, Vital Statistics and Climatology.

14. Military and Naval Surgery and Medicine.

15. Practical and Experimental Therapeutics.

16. Diseases of Children.

3. The general meetings shall be reserved for the transaction of the general business of the Congress, and for addresses or ommunications of scientific interest more general in character than those presented in the Sections.

4. Questions which have been agreed upon for discussion in the Sections shall be introduced by members previously nominated by the officers of the Sections. The members who may be appointed to open the discussions shall present, in advance, a statement of the conclusions which they have formed as a basis for debate.

5. Notices of papers to be read in any of the Sections, together with the abstracts of the same, must be sent to the Secretary of that Section before April 30, 1887. These abstracts will be regarded as confidential communications, and will not be published until the meeting of the Congress. Papers relating to questions not included in the list of subjects suggested by the officers of the various Sections will be received. Any member, after April 30, wishing to bring forward a subject not upon the programme, must give notice of his intention to the Secretary-General at least twenty-one days before the opening of the Congress. The titular officers and Council of each Section shall decide as to the acceptance of any communication offered to their Section, and shall fix the time of its presentation. No communication will be received which has been already published or read before a Society.

6. All addresses, papers and discussions made either at general meetings or in the Sections are to be immediately handed to the Secretaries. The Executive Committee, after the

conclusion of the Congress, shall proceed with the publication of the Transactions, and shall have full power to decide which papers shall be published, and whether in whole or in part.

7. The official languages are English, French and German.

In the Sections no speaker will be allowed more than ten minutes, with the exception of readers of papers and those who introduce debates, who may occupy twenty minutes.

8. The rules, programmes and abstracts of papers shall be published in English, French and German.

Each paper or address will appear in the Transactions in the language in which it was delivered by the author. The debates will be printed in English.

9. The officers of the Committee of Arrangements shall be a Chairman, Vice-Chairman and a Secretary.

10. There shall be an Executive Committe, to be composed of the Chairman, Vice-Chairman, Secretary-General, Treasurer, the Chairman of the Finance Committee, the Secretary and five other members, to be elected by the Committee of Arrangements. The duties of the Executive Committee shall be to carry out the directions of the Committee of Arrangements, to authorize such expenditures as may be necessary, and to act for the Committee during the intervals of its sessions, reporting such action at the next meeting of the Committee, for approval.

11. There shall be a Standing Committee on Finance, composed of one person from each State, Territory, the District of Columbia, the Medical Departments of the Army, Navy and the Marine Hospital Service. The Chairman of the Finance Committee shall be *ex officio* one of the Vice-Presidents of the Congress, and also a member of the Executive Committee. The Committee of Arrangements shall appoint

the Finance Committee, and each State chairman appoint the local Finance Committee of one from each Congressional District.

12. The officers of the Congress shall be a President, such number of Vice-Presidents as may hereafter be determined on, a Secretary-General, two Assistant Secretaries, also to be hereafter appointed, and a Treasurer, and those elected to these positions will be nominated by the Committee of Arment, to hold the same offices in the Congress.

Dr. Austin Flint was continued as President of the congress, as were many of the other officers previously selected. In fact, the personel of the congress was not greatly changed. Two of the Vice-Presidents were not continued, and eleven others were added. The Secretary-General declined to be continued, and another was elected to that office.

The number of the sections was reduced from nineteen to sixteen, by merging sections. Twelve of the Presidents of sections remained unchanged. The merging of sections changed three of the presidents, and four others were not continued.

In the offices of Vice-President, Secretary and Council, the principal changes made were in enlarging the number of each.

The principal changes made in the rules for the government of the congress consisted in requiring that "the American members of the congress shall consist of delegates from the American Medical Association, and the medical societies in affiliation with the American Medical Association," which restricted the American membership even more than the conditions imposed by the "original enlarged committee," and made the same mistake of proposing two classes of members for the congress. Another change reduced the number of the sections, and, consequently, of presidents of sections, as pre-

viously stated. But little change was made regarding the organization and the work of the sections.

Having progressed thus far toward the organization of the congress, the Committee of Arrangements adjourned.

After the adjournment it was charged that the action taken was partisan, hasty and ill-advised, and in contravention of the best interests of the congress, for which alleged reasons numerous resignations from the organization occurred.

The second meeting of the Committee of Arrangements was held in New York city, on the 3rd of September. The following named members were present:

Dr. G. Baird, Dr. Robert Battey, Dr. L. P. Bush, Dr. R. Beverly Cole, Dr. W. C. Dabney, Dr. Ellsworth Eliot, Dr. A. Y. P. Garnett, Dr. S. C. Gordon, Dr. J. W. S. Gouley, Dr. J. B. Hamilton, Dr. George A. Ketchum, Dr. R. A. Kinloch, Dr. D. A. Linthicum, Dr. John S. Lynch, Dr. R. C. Moore, Dr. William Pierson, Dr. N. J. Pitman, Dr. L. A. Sayre, Dr. X. C. Scott, Dr. John V. Shoemaker, Dr. F. L. Sim, Dr. E. F. Upham, Dr. W. H. Wathen, Dr. W. C. Wile, Dr. A. H. Wilson.

Other members were represented by proxies:

Dr. E. P. Cook, by Dr. N. S. Davis, proxy; Dr. A. R. Smart, by Dr. William Brodie, proxy; Dr. J. M. Taylor, by Dr. E. P. Sale, proxy.

The committee was called to order September 3rd, 1885, by the Chairman, Dr. R. Beverly Cole.

The resignation of Dr. L. A. Sayre, of New York, as member of the committee was tendered in consequence of his ill-health. It was accepted, and Dr. A. Flint, Jr., of New York, was elected to fill the vacancy and took his seat with the committee.

There were seven vacancies in the Committee of Arrangements, and the following gentlemen were elected to fill their vacancies:

Dr. J. Bartlett, Wisconsin; Dr. J. H. Baxter, U. S. Army; Dr. George Goodfellow, Arizona; Dr. Henry Leffman, Pennsylvania; Dr. John Morris, Maryland; Dr. J. R. Tipton, New Mexico; Dr. Thomas J. Turner, U. S. Navy.

It was decided that no person should occupy more than one position in the organization of the congress.

It was also decided that, in the published lists of the officers of the congress, the names of the Vice-Presidents and Secretaries of the congress, and the Vice-Presidents, Secretaries and members of Councils of the Sections, should be arranged alphabetically.

The Section of Medical Education was discontinued. The Sections of Gynæcology and Psychological Medicine and Diseases of the Nervous System, and of Dental and Oral Surgery were restored. The Section of Laryngology was united with that of Otology.

In the interval between the first meeting of the committee in Chicago, in June, and the second meeting in New York, in September, it had become evident that it was not best to make two classes of members of the congress, and that no effort should be made to make the congress a delegated body. Therefore the Committee of Arrangements wisely concluded to remove all previous restrictions imposed, and to make the requirements for membership as liberal as they had been in any congress yet held, and adopted the following plan of organization:

THE RULES ADOPTED ARE:

1. The congress shall consist of members of the regular profession of medicine, who shall have inscribed their names on the register and shall have taken out their tickets of admis-

sion; and of such other scientific men as the Executive Committee of the congress may see fit to admit.

2. The dues for members of the congress shall be ten dollars each for members residing in the United States.

There shall be no dues for members residing in foreign countries.

Each member of the congress shall be entitled to receive a copy of the "Transactions" for 1887.

3. The congress shall be divided as follows, into seventeen sections:

I. General Medicine.
II. General Surgery.
III. Military and Naval Surgery.
IV. Obstetrics.
V. Gynæcology.
VI. Therapeutics and Materia Medica.
VII. Anatomy.
VIII. Physiology.
IX. Pathology.
X. Diseases of Children.
XI. Ophthalmology.
XII. Otology and Laryngology.
XIII. Dermatology and Syphilis.
XIV. Public and International Hygiene.
XV. Collective Investigation, Nomenclature, Vital Statistics, and Climatology.
XVI. Psycological Medicine and Diseases of the Nervous System.
XVII. Dental and Oral Surgery.

4. The general meetings of the congress shall be for the transaction of business and for addresses and communications of general scientific interest.

5. Questions and topics that have been agreed upon for discussion in the sections shall be introduced by members previously designated by the titular officers of each section. Members who shall have been appointed to open discussions shall present in advance statements of the conclusions which they have formed as a basis for debate.

6. Brief abstracts of papers to be read in the sections shall be sent to the secretaries of the proper sections on or before April 30, 1887. These abstracts shall be treated as confidential communications, and shall not be published before the meeting of the congress.

Papers relating to topics not included in the lists of subjects proposed by the officers of the sections may be accepted after April 30, 1887; and any member wishing to introduce a topic not on the regular lists of subjects for discussion shall give notice of the same to the secretary-general, at least twenty-one days before the opening of the congress, and such notices shall be promp ly transmitted by the secretary-general to the presidents of the proper sections. The titular officers of each section shall decide as to the acceptance of such proposed communications and the time for their presentation.

7. All formal addresses, scientific communications and papers presented, and scientific discussions held at the general meetings of the congress, shall be promptly given in writing to the secretary-general; and all papers presented and discussions held at the meetings of the sections shall be promptly given in writing to the secretaries of the proper sections.

No communication shall be received which has already been published, or read before a society.

The Executive Committee, after the final adjournment of the congress, shall direct the editing and the publication of its "Transactions," and shall have the full power to publish the

papers presented and the discussions held thereon, either in full, in part, or in abstract, as in the judgment of the committee may be deemed best.

8. The official languages of the congress shall be English, French and German.

In the meetings of the sections, no member shall be allowed to speak for more than ten minutes, with the exceptions of the readers of papers and those who introduce subjects for discussion, who may each occupy twenty minutes.

9. The rules and programmes shall be published in English, French and German.

Each paper and address shall be printed in the "Transactions" in the language in which it was presented, and preliminary abstracts of papers and addresses also shall be printed, each in the language in which it is to be delivered.

All discussions shall be printed in English.

10. The president of the congress, the secretary-general, the treasurer, the chairman of the Finance Committee, and the presidents of the sections, shall together constitute an Executive Committee of the congress, which committee shall direct the business of the congress, shall authorize all expenditures for the immediate purposes of the congress, shall supervise and audit the accounts of the treasurer, and shall fill all vacancies in the offices of the congress and of the sections. This committee shall have power to add to its membership, but the total number of members shall not exceed thirty. A number equal to one-third of the members of the committee shall constitute a quorum for the transaction of business.

11. The officers of the congress shall be a president, vice-presidents, a secretary-general, four associate secretaries, one of whom shall be the French secretary, and one of whom

shall be the German secretary, a treasurer, and the chairman of the Finance Committee.

12. The officers of each section shall be a president, vice-presidents, secretaries, and a council.

13. The officers of the congress and the officers of the sections shall be nominated to the congress at the opening of its first session.

14. The Executive Committee shall, at some convenient time before the meeting of the congress, prepare a list of foreign vice-presidents of the congress and foreign vice-presidents of the sections, to be nominated to the congress at the opening of its first session.

15. There shall be a standing Committee on Finance, composed of one representative from each state and territory, the District of Columbia, the medical department of the army, the medical department of the navy, and the marine hospital service.

The chairman of the Finance Committee shall report to the Executive Committee of the congress.

Each member of the Finance Committee shall appoint a local Finance Committee for his state, territory, district, or government department, consisting of one or more members from each government department or congressional district.

Each local Finance Committee shall report through its chairman to the chairman of the Finance Committee of the congress.

The committee then proceeded to fill the more important positions found to be vacant in the organization of the congress. The following is a correct list of the general officers of the congress, including Vice-Presidents, and also the Presidents of the seventeen sections:

PRESIDENT.

Austin Flint, M. D., LL. D., New York.

VICE-PRESIDENTS.

W. O. Baldwin, M. D., Alabama; *H. I. Bowditch, M. D., Massachusetts; William Brodie, M. D., Michigan; *Henry F. Campbell, M. D., Georgia; W. W. Dawson, M. D., Ohio; *R. Palmer Howard, M. D., Canada; E. M. Moore, M. D., New York; Tobias G. Richardson, M. D., Lousiania; Lewis A. Sayre, M. D., New York; J. M. Toner, M. D., District of Columbia; the President of the American Medical Association; the Surgeon-General of the United States Army; the Surgeon-General of the United States Navy; the Supervising Surgeon-General of the United States Marine Hospital Service.

SECRETARY-GENERAL.

Nathan S. Davis, M. D., LL. D., Chicago, Illinois.

TREASURER.

E. S. F. Arnold, M. D., M. R. C. S., New York.

CHAIRMAN OF THE FINANCE COMMITTEE.

Frederick S. Dennis, M. D., M. R. C. S., New York.

EXECUTIVE COMMITTEE OF THE CONGRESS.

GENERAL OFFICERS.

Austin Flint, M. D., LL. D., President of the Congress.

Nathan S. Davis, M. D., LL. D., Secretary-General.

E. S. F. Arnold, M. D., M. R. C. S., Treasurer.

Frederick S. Dennis, M. D., M. R. C. S., Chairman of the Finance Committee.

PRESIDENTS OF THE SECTIONS.

General Medicine.—Abram B. Arnold, M. D.

General Surgery.—William T. Briggs, M. D.

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*Since resigned.

Military and Naval Medicine and Surgery.—Henry H. Smith, M. D.

Obstetrics—DeLaskie Miller, M. D., Ph. D.

**Gynæcology.*—Robert Battey, M. D.

Therapeutics and Materia Medica.—F. H. Terrill, M. D.

Anatomy.—William H. Pancoast, M. D.

**Physiology.*—John C. Dalton, M. D.

**Pathology.*—E. O. Shakespeare, M. D.

Diseases of Children.—J. Lewis Smith, M. D.

Ophthalmology.—A. W. Calhoun, M. D.

Otology and Laryngology.—S. J. Jones, M. D., LL. D.

Dermatology and Syphilis.—A. R. Robinson, M. D.

Public and International Hygiene.—Joseph Jones, M. D.

Collective Investigation, Vital Statistics, and Climatology.—Henry O. Marcy, M. D.

Psychological Medicine and Nervous Diseases.—John P. Gray, M. D., LL., D.

Dental and Oral Surgery.—Jonathan Tafft, M. D.

LOCAL COMMITTEE OF ARRANGEMENTS.

(With power to increase the number.)

A. Y. P. Garnett, M. D., Chairman, Dist. of Columbia.

The Surgeon-General U. S. Army.

The Surgeon-General U. S. Navy.

The Supervising Surgeon-General U. S. Marine Hospital Service.

J. H. Baxter, M. D., District of Columbia.

C. H. A. Kleinschmidt, M. D., District of Columbia.

N. S. Lincoln, M. D., District of Columbia.

J. M. Toner, M. D., District of Columbia.

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*Since resigned.

Lists of Vice-Presidents, Secretaries, and Councilmen for each section were named by the Committee of Arrangements, but as it was not practicable to ascertain at once who would accept the places assigned them, or who of those who had been announced in the medical press as declining to accept positions before the present rules and organization had been adopted as given above might wish to withdraw such declination, the final adjustment of these offices was referred to the Executive Committee of the congress, and all correspondence in relation thereto was transferred to the Secretary-General of the congress.

Having thus selected the officers of the congress and the presidents of the sections, who together were made an "Executive Committee," the committee of arrangements considered its work practically completed, and placed the affairs of the congress in charge of the "Executive Committee," and now awaits the assembling of the American Medical Association in St. Louis, in May next, to report the completion of the work assigned to it by the Association, whereupon the Association will be in position to say to the medical profession of the country that it discharged the duty undertaken by it, of extending an invitation to have the ninth congress held in Washington; that the invitation was accepted and that, through its committee of arrangements, the congress has been organized and the affairs of the congress placed in charge of the executive committee of the congress, and that the Association need no longer regard itself as holding any official relation to the congress.

It was with this understanding of its status that the Executive Committee assumed the management of the work of the congress, and it so announced after its first meeting and organization.

The first meeting of the executive committee of the congress occured in New York city on September 24th, and was organized by electing Henry H. Smith, M. D., Chairman. The office of Associate Secretary-General was created, and F. S. Dennis, M. D., was elected to that office, and R. J. Dunglison, M. D., was elected chairman of the finance committee, in place of F. S. Dennis, transferred.

After the transaction of some routine business, and directing that an official announcement be made that the preliminary organization of the congress had been effected, the committee adjourned.

The second meeting of the executive committee occured in New York city on November 18th. There being vacancies in the office of President of three of the sections, the executive committee numbered nineteen; of these, fifteen were present.

R. J. Dunglison, M. D., was elected permanent Secretary of the committee. Some routine business was transacted, and some vacancies in some of the sections were filled.

Then, acting under the authority conferred upon the executive committee by rule ten, and as contemplated by the committee of arrangements when it transferred the affairs of the congress to the executive committee, the latter committee unanimously elected six additional members of the committee, viz.:

J. S. Billings, M. D., U. S. Army; J. M. Browne, M. D., U. S. Navy; Christopher Johnston, M. D., of Baltimore, and G. J. Engleman, M. D., of St. Louis, all of the "original committee", and, also, William Pepper, M. D., and J. M. Da Costa, M. D., both of Philadelphia.

It was then decided to postpone the filling of the other vacancies, including the presidencies of the three sections, in

order that the newly-elected members might participate in filling them, if they should accept the positions to which they had been elected.

This course on the part of the committee was taken in recognition of the fact that there exists much misunderstanding in the profession regarding the organization of the congress, which fact has prevented the cordial coöperation of many whose recognized rank in the medical profession entitles them to prominent positions in a congress, international and important in character. The committee appreciated the fact that it now stands in a capacity of trust, not alone for the medical profession of the United States, much less for factions in it, but for the entire medical profession that is expected to participate in the congress, and that its course of action should be such as would give evidence that it appreciated the fact and felt the responsibility that attaches to such an important trust. It therefore sought, in making selection of those to be added, to elect such as would properly represent those not represented in the preliminary organization. Having done this, the committee adjourned, and awaits the action of the newly-elected members.

The American Academy of Medicine was organized in 1876, mainly with a view of encouraging a more liberal preliminary education of those contemplating the study of medicine, in the belief that this is the first and most important step toward securing a higher standard of medical education in the United States. The Academy has steadily grown until its membership now embraces about three hundred physicians, who have received the degree of Bachelor of Arts, in course, from recognized colleges or universities.

Having secured a recognized position, and exerted a bene-

ficial influence on the medical profession of our country, it is believed by many members of the Academy that its sphere of usefulness may be still further extended by admitting to membership physicians who have justly attained prominence in our profession, and, as an evidence thereof, and as a reward for good work accomplished, have received honorary degrees, from reputable institutions.

This enlargement was advocated by President Gihon in his annual address, at the last annual meeting of the Academy, in New York, in October, and the subject will be considered at the next annual meeting of the Academy, in Pittsburg, in September, 1886, just ten years after its organization.

The Annual Report of the Surgeon-General of the United States Army, 1885, is a pamphlet of 93 pages, which presents the medical statistics of the army and details as to the work of the Surgeon-general's office, with the precise carefulness which has marked all the publications having the same imprint for all the years since the civil war. The mean strength of the army for the year is set down as 24,035. This body of men furnishes 36,829 records of admission for hospital or other treatment, with 263 deaths. The order of the diseases, as they occurred, possesses some interest, as the soldiers were presumably scattered throughout all parts of the American Union, and hence the average, in some small measure, represents the average of diseases of men in similar hygienic environment all over the country, women, of course, being excluded. First come traumatisms, which may be, perhaps, set down as in a sort peculiar to the army life; second, diseases of the respiratory tract; next, those diseases of the gastro-intestinal tract producing diarrhœa and kindred maladies; next, the malarial group of troubles; and then, in the order named, digestive disorders exclusive

of tonsilitis; nervous affections, from headache to those of a severer grade, exclusive of insanity; disorders connected with alcoholism; the venereal diseases, exclusive of constitutional syphilis; tonsilitis; and lastly, cutaneous disorders. The army medical museum received a large addition during the year. It is interesting to note that the 3rd medical volume of the Medical and Surgical History of the War, the last of this series, will probably be completed during the coming winter.

The Annual Report of the Surgeon-General of the United States Navy, is comprised in a pamphlet of nine pages, which, being printed at the Government Printing Office instead of by the Bureau itself, compares unfavorably in typographical appearance with the Army Report. In the force afloat for the year, represented by the figures 9,959, there were 78,659 entries of sick on the rolls, the traditions of the navy being such that a man who is ill for six days counts as six men in the same condition for one day. The order of diseases represented in the list is, first, violent diseases and deaths; next, constitutional diseases; and then, diseases of the genito-urinary system; of the integumentary system; of the digestive system; zymotic diseases; respiratory diseases, etc. The difference between the health of the army and of the navy with respect to the class of disorders affecting the respiratory organs is most marked, and is highly suggestive of the salubrity of the sea and the modifications impressed by it upon the climate.

Special attention should be directed to the museum of hygiene under the charge of Medical-director Browne. A large number of contributions have been made to it during the year, such as articles illustrating drainage, plumbing, water-supply, ventilation, household-health, disposing of the dead, etc., and books, instruments, etc.

On the outside of the museum is being constructed a complete system of iron and lead pipes, with fixtures, running from the ground to the roof, with an observing station at each of the three stories, for an exhaustive series of experiments covering all the topics in dispute relating to trap-siphonage, and the utility of the mechanism of water-closets, traps, water-basins, baths, sinks, etc. The results of this novel enterprise on the part of the Bureau will be watched with interest, as the experiments will be conducted in the cause of science alone, uninfluenced by any of the commercial interests which, it is feared, have too often given coloring to results supposed to have been obtained in experiments, presumably conducted in the interest of sanitary science. The work in this museum has been conducted without ostentation, and but few are aware how much this collection of models and plans and sanitary devices will yet influence sanitation at sea and on land. A liberal appropriation by congress for the further development of the work undertaken in the formation of this valuable museum, will enable those directing it to carry out their cherished plan of making it useful in the direction of prevention of sickness, rather than of its remedy, which is now engaging the attention of sanitarians, who recognize in it the highest calling of the physician.

DOMESTIC CORRESPONDENCE.

JEWELL CITY, KANSAS, Nov. 3rd, 1885.

TO THE EDITORS OF THE *Chicago Medical Journal and Examiner.*

Gentlemen:

The following is an incomplete history of a case which, if deemed interesting, please use as you see proper.

On January 22nd, 1885, I was called to see Mrs. N. J., age twenty-six years, mother of five children, who had been confined to her bed for the past twelve weeks by what her physician called typhoid fever. Her youngest child was about two weeks old when the fever came on. I found her greatly emaciated, delirious, and with tongue heavily coated. Temperature 102° F. Her pulse 128° per minute. There was complete anorexia and some thirst. I was told that she had been "troubled with bloating for about four weeks." Upon inquiry, as to the action of her kidneys, I was told that she passed urine frequently, but only a little at each time, and that she had been taking a diuretic for some time to correct that trouble. Upon passing my hand over the emaciated walls of the abdomen, I could feel the urinary bladder greatly distended. Objection was made to my passing a catheter, as "she passed water nearly all the time." After emptying the bladder, the quantity of urine obtained was so large that I measured it, accurately, and found it to be sixty-one and one-half fluid ounces, or a little more than ten [?] pints. After this the bladder was emptied three or four times during each twenty-four hours. The patient became rational; her tongue

cleared off; her appetite improved, and her sleep became natural; but the patient being emaciated more than anything that I ever expected to see, died on the 26th from inanition.

The only point of interest in this case is the great quantity of urine obtained from this patient at one time, which far exceeds the quantity that the bladder is generally believed to be capable of holding. It is a much larger quantity than I have ever heard of, and I thought it might be interesting to others.

Respectfully yours,

F. A. BUTTERFIELD.

FŒTUS COMPRESSUS.

TO THE EDITORS OF THE *Chicago Medical Journal and Examiner.*

Gentlemen:

On April 19th, 1879, I was called to attend Mrs. P., 25 years old, of nervous temperament, healthy, good family history, in her first confinement. After a somewhat protracted, though normal labour, she was delivered of a fairly nourished female child, weighing eight pounds. Immediately preceding the expulsion of the placenta, which followed a few minutes after the birth of the child, a four months' *fœtus compressus* was expelled. The head of the fœtus was flattened from side to side and turned with the chin to the shoulder, while the body was flattened from before backward. The placenta was not examined closely. The mother had some pain and hæmorrhage at the fourth month, which was controlled by rest and opium. She was fully as large at four as at six months, growth seeming to stop after these symptoms until the latter months of pregnancy. The living child never seemed robust and died at the age of three months, from whooping-cough. The mother has

been delivered of three children since,—all normal labours,—and all the children are living and healthy at the present time. The *fœtus* was a male.

MILES F. PORTER, M. D.

Fort Wayne, Indiana.

SOCIETY REPORTS.

CHICAGO MEDICAL SOCIETY.

Stated Meeting, November 4th, 1885.—The PRESIDENT, C. T. PARKES, M. D., in the chair.

NERVOUS PAROXYSM, OR SYNCOPE, was the subject of a paper by DR. H. T. BYFORD. He read the report of two fatal cases, which had not occurred in his own practice, and traced the cause of death to strangulation by medicine given during the paroxysms. The third case reported occurred in his own practice and recovered, no attempt at internal medication having been made during the paroxysms. After a recital of the cases, the author proceeded to describe this hitherto imperfectly recognized form of nervous paroxysm, which, in the books and in practice, is often confounded with true syncope, hysteria and other conditions, but which is in reality more in the form of convulsions.

In the cases which he had treated, the most common exciting causes lay in the digestive system, but he thought subsequent observations would demonstrate that the exciting causes might also be due to some disturbance of the cutaneous, osseous, sexual or urinary systems. The predisposing causes are debility, plethora, sudden change of habits, severe strains upon vital forces, parturition, functional or organic diseases, etc.

The author tabulated the symptoms occurring in true syncope and nervous paroxysm, as follows:

TRUE SYNCOPE.	NERVOUS PAROXYSM.
1. Often preceded by a feeling of oppression about the epigastrium, or nausea and general malaise. Patients feel the attack coming on.	1. Often preceded by nervous irritation, heaviness about the stomach, and frequent desire to take a deep inspiration (gaping); sometimes by a feeling of nervous exaltation, or equanimity greater than usual. Onset is usually sudden.
2. Pallor, vacant expression of countenance, and mental calm in the beginning, with dullness of special and general sensation.	2. Pallor, anxious countenance, mental distress in the beginning, with acuteness of special and general sensation.
3. Muscular relaxation.	3. Muscular rigidity or activity.
4. Dyspnœa, if any, not distressful—objective rather than subjective.	4. Dyspnœa distressful — more subjective than objective.
5. Unconsciousness absolute.	5. Seldom absolute unconsciousness, mental confusion or incapacity.
6. Unless fatal, attack passes away rapidly, especially if patient in recumbent position.	6. Passes away gradually, more rapidly if head and shoulders be elevated.
7. Temperature normal or below (unless elevated by disease).	7. Temperature normal or above.
8. Seldom recurs if head be kept low.	8. Usually recurs, or threatens to recur shortly, even if patient lie down.
9. Heart's action greatly depressed.	9. Heart's action irregular, spasmodic, and only moderately depressed.
10. Seldom very disagreeable recollections of distress during the attack.	10. Very disagreeable recollections of distress during the paroxysms.
11. Stimulants afford relief.	11. Stimulants aggravate.

Hysteria, uræmia, the action of remedies. etc., may complicate and obscure the symptoms in any given case. The treat-

ment calls for counter-irritation, cool air, cold drinks, massage, antispasmodics, for the paroxysms; afterwards, a removal of the cause, if possible, and measures for the restoration of good health.

DISCUSSION.

PROFESSON J. H. ETHERIDGE: I would like to ask DR. BYFORD what he would think of the use of hypodermic injections of digitalis under such circumstances; to ask if any one has ever used it in cases of acute syncope; and why it would not be a good thing to make use of?

DR. H. T. BYFORD: In these attacks I believe digitalis would perhaps hardly be the remedy, for the condition is one of reflex irritation, I think. I think it is a case of spasmodic contraction of the heart, and that any nervous symptoms are the result of a contraction of the arterioles of the brain rather than a falling off in the force of the circulation, and that stimulants, such as digitalis, would be liable to do harm. This class of cases I have considered really attacks of convulsions, in which consciousness is not lost, if such a thing can be admitted. In these cases consciousness is not lost; sometimes there is a partial loss of consciousness, spasmodic contraction of the diaphragm, the breath almost entirely cut off, and I suppose the same spasmodic condition of the heart; and sometimes, and in some of the cases referred to, there was rigidity of the muscles; one patient tried to throw herself out of bed. In real syncope the attacks involve loss of consciousness, and relaxation of the muscles. Dr. G. NEWKIRK has informed me that he formerly treated cases of malaria wherein the onset was marked by symptoms such as have been described. These cases, occurring in a malarial district, were characterized by a foul stomach, due to the presence of acrid ingesta. Free vomiting, spontaneous or induced, nearly always gave relief.

PALATABLE THERAPEUTICS was the subject discussed in a paper read by Dr. FRANKLIN H. MARTIN. He exhibited specimens of drugs manufactured in the form of pills, capsules, granular salts, elixirs, et cetera, either tasteless or palatable. In his paper, DR. MARTIN claimed that many of the greatest improvements in therapeutics have been gleaned from the field of charlatanism. Electricity, massage and the "Swedish movement" have been wrested from this domain, and placed upon a legitimate and scientific basis. The author claimed that homœopathic medication had three valuable characteristics, palatability, harmlessness and inexpensiveness to the patients. This combination, absolutely without medical merit, accounts for the so-called success of homœopathy. If we can secure palatability to our remedies, we will do much to overcome the popular aversion to our medicinal preparations. Since 1817, when morphia was first isolated as an alkaloid, a great advance has been made in discovering the active principles of drugs. Of the alkaloids there have now been discovered twenty-two, with actions similar to the parent drugs. They are manufacfactured in pill form and are more easy of administration than the disagreeable preparations from the crude drugs. Twenty glucosides have been similarly isolated and manufactured. While this branch of pharmaceutical chemistry is yet in its infancy we can confidently look forward to the day when the active principles of all the organic drugs will have been discovered, isolated and manufactured into palatable preparations. To-day, the salts of various metals, solid extracts, the bromides and iodides, chloral hydrate and the oils can all be administered in capsules. DR. MARTIN claimed to be the first to suggest the enclosing in capsules solutions of chloral in oil. We can summarize the means by which we can make medicines palatable, as follows: The administration of alkaloids, solid ex-

tracts, crude drugs of small bulk, and various salts in capsules or gelatine or sugar-coated pills; the administration of glucosides and neutral principles in gelatine or sugar-coated granules; the administration of tasteless liquids in water; the administration of oils, oleo-resins, oleates and drugs soluble in oil in soft elastic gelatine capsules; and the administration of medicines by the hypodermic syringe, suppositories and inunctions.

DISCUSSION.

DR. J. J. M. ANGEAR: The object of the paper is certainly commendable. I think the latter part of the paper is valuable, where is urged upon us the necessity of discarding these nauseating remedies and availing ourselves of the science of chemistry, and we should take the admonition to ourselves. I think we are injuring ourselves and our profession by prescribing such crude material when we might avail ourselves of more modern and elegant remedies.

DR. R. TILLEY: There is an inference, of course, even more manifest than appears in the title of the paper which was read to us, that we are indebted more or less to the homœopathists for the advance which we have made in the years gone by in the administration of medicines in a more palatable form. I claim, most emphatically, that such is not the case. The advance which we have made in this respect is to a large extent due to our chemists, and we are willing to accord to them the credit which belongs to them, but we are not willing to accord this credit to the homœopathists. Certainly we have all taken this subject into consideration; we have all given morphine, atropia, etc., when desired. All of us have, I am sure, been trying our best to render these medicines as palatable as possible. There, are, however, a few recommendations in the paper which I think would be most objection-

able. For instance, I dare say few experienced men would dare to give iodide of potassium in large doses in capsules. I always recommend large quantities of water to be taken in connection with iodide of potassium. Then with reference to arsenic and antimony, we are told they can be administered in solutions in teaspoonful doses. We all know that, but I question whether it is desirable. I have always recommended the administration of arsenic in large quantities of water, and also tartar emetic. As to the administration of chloral in oil in capsules, I think the Doctor can claim the credit and have all the honor associated with it. There is one thing I would like to refer to, that is the administration of permanganate of potassium in capsule form. I have known it to be so administered in two or three cases, with very severe pain attending the administration, but I have never administered it in that way myself.

PROFESSOR J. H. ETHERIDGE: I think the paper is a very timely one, it is full of a great many good points, but I think there is an objection to the administration of concentrated remedies, especially these alkaloids, in gelatine covers and sugar-coated pills. It sometimes happens that after they have been administered they do not dissolve, and then we get a terrific effect by a half dozen dissolving at once, and in some cases they do not dissolve at all. I recall a case where it was decided to give a child thirty-five grains of quinine; seven capsules were administered and three of them passed the rectum untouched. They may not always promptly dissolve, and the consequence is we run a very great risk of injuring our patients.

DR. A. H. FOSTER: I am glad we have arrived at the point where our profession has learned to give less medicine, thus it is more palatable. Another thing, it is time that we began giving medicine more palatably by giving it in smaller

doses, and we will often get a primary and not a secondary effect from our remedies, and will not get that terrible perturbation that we would if we gave large doses. Some of us have to deal with very delicate stomachs; that class of my practice which is more in the middle of the west side is more delicate than on the outskirts where they live more rough and ready, and I have to be a great deal more careful with these people who live more centrally, and make the doses smaller and more frequent to get the desired effect. But the point that I wish to make is, that we can and do have to study the palatability of our remedies. Another point is, that we have learned to simplify our remedies. I have had more than one physician prescribe in my family, and I always got along best with the one who didn't fire off shot-gun prescriptions. We very often fire shot-gun prescriptions, putting in cathartics and nervines into the same prescription; I would rather it would be one thing at a time and for a definite purpose.

PROFESSOR D. A. K. STEELE: There are a good many valuable points in this paper, and I think the criticism has pretty effectually squelched the objectionable ones. The author claims very valuable points from homœopathy; first, the palatability of their remedies; next, their safeness, that there is no danger in their remedies. That element of safety in prescribing we have applied in our own treatment, some of us, not from belief in homœopathy, but from unerring experience. After having almost killed a few patients in my early months of practice, with large doses and polyglot prescriptions, I came down to smaller doses and found them much safer. Now in reference to some of the objections that may be urged against palatable remedies; the objection to pills is their insolubility, the fact that they pass through the alimentary canals unchanged. I have repeatedly found them undissolved; found

that in administering quinine in that form I did not get the desired result. I think the author made a mistake in giving too little credit to our pharmacists for the advances made in pharmacy in late years. The essential point of the paper, to my mind, is the fact that it impresses upon us the importance of giving less medicine and of giving it in a more palatable form.

DR. C. E. WEBSTER: There is a point we can learn from homœopathy, one lesson which, it seems, has not been touched upon, and that is that in the vast majority of ordinary acute diseases, careful nursing and absolutely inert remedies bring very creditable, if not the best, results; inert remedies which simply occupy the attention of the patient, will produce favorable results. This is the important and only lesson that can be learned from homœopathy.

DR. R. TILLEY: Dr. Foster seemed to imply that we get our tendency to give small doses from the homœopaths. I take the opportunity of saying that in the large hospitals in Paris and London, they have placed patients with acute affections side by side, and to the one they have given all the medicine they have thought necessary, and to the other they have given careful attention and nursing, with the suggestions a practical physician would give, and there has been practically no difference in the result in the two classes of cases. Experience has taught us to give in certain cases, or in many cases, simply a teaspoonful of water occasionally, and that is very important especially in children; a teaspoonful of water is frequently all that the child needs, although few people seem to realize the fact.

DR. DOERING: I object to crediting homœopathy with what science and chemistry have accomplished. Take the alkaloids, they have all been discovered in Germany, where homœopathy cannot live at all,—where they have not a single chair in

any university. I think the paper would be much more valuable if all the reference to homœopathy had been omitted. Palatable medicines are simply the natural result of the advance of the science of medicine, chemistry and pharmacy.

PROFESSOR C. T. PARKES: I recall one instance which illustrates the fact that palatable medicines are not always innocent and harmless. I was called to make a post-mortem examination on a boy six years old. Upon opening the abdomen I found in the abdominal cavity a round mass, and upon examination of this round mass it was found to be a sugar-coated quinine pill. These were also found in the vermiform appendix and had ulcerated through into the abdominal cavity. So far as my opinion as to homœopathy is concerned, I wish to go on record as agreeing entirely with DR. DOERING.

DR. F. H. MARTIN closed the discussion by saying: In regard to the iodide of potassium, DR. TILLEY mentioned that he always gives iodide of potassium diluted in large quantities of water. When I was considering iodide of potash, I recalled the experience that I had myself in administering it, so I diluted the drug after getting it into the stomach; that is, I gave the patient water after he swallowed the capsule, and he experienced no trouble. In regard to permanganate of potash, it is not necessary to give it in capsules,—the oleate of manganese can be used by inunction, or the permanganate of potash be given in distilled water. In regard to the solubility of these pills, any of the best pills will dissolve in water in such a way that the remedies will become free in three minutes. If a capsule or pill of morphia be put in cold water, you can taste the morphia after it has been in the water not longer than two minutes, and you can readily see that by putting the pill into the stomach the gastric fluid, the temperature, and the muscular action, would soon cause its solution. In regard to

the suggestion made by DR. WEBSTER, that the only lesson to be learned from homœopathy was the fact that a large per cent. would recover without remedies, I think I included that in my citing homœopathy as a lesson in general, for we all know from the success of homœopathy, if all their patients had died, or the majority of them had died, homœopathy would have gone out of existence immediately. But it was not the case, and it was taken for granted in the paper that the palatability and harmlessness of their remedies was the first great lesson of the evening and the paper. In regard to quinine pills, some time ago I believe that medicine was put up with sulphuric acid, and it lost strength and became almost inert, but now they put quinine up in excipients that will dissolve readily, and, also, loosely in flexible capsules.

The Society then adjourned.

CHICAGO MEDICAL SOCIETY.

Stated Meeting, November 16th, 1885.—The PRESIDENT, C. T. PARKES, M. D., in the chair.

A REPORT EMBODYING TWO HUNDRED CASES OF TONSILITIS, was the title of a paper read by DR. J. M. G. CARTER, of Waukegan, Illinois.

After detailing the treatments which had been employed in the cases, the author advanced the theory that since the great majority of the cases occurred during March, April and May, when northeast winds prevailed, carrying landward more moisture from Lake Michigan, these winds must be one of the casual factors in the production of tonsilitis. Also, the test for ozone during these months showed a greater percentage of ozone in the atmosphere. Another fact was noticed, that a great many cases occurred in rheumatic patients. The author

was of the opinion that the epidemic of cases detailed was due to the damp northeast winds, containing an excess of ozone, and to unusually disturbed electrical conditions of the atmosphere. The author grouped the two hundred cases, without classifying them, into cases of simple, diphtheritic or scarlatinous tonsiiitis. He mentioned, however, the fact that cases of simple tonsilitis were often accompanied or followed by attacks of diphtheria or scarlet-fever among other members of the family.

DISCUSSION.

PROFESSOR F. O. STOCKTON said: We have tonsilitis in nearly all the eruptive fevers, usually following, and occasionally preceding them. The author refers to cases having diphtheritic patches on the tonsils; I think he has confounded these diphtheritic cases with what we specialists call follicular tonsilitis. It is not a diphtheritic condition at all, but resembles it very greatly, so that in a differential diagnosis these cases are very often confounded. In regard to the temperature going up to 104, it is my experience, and that of authorities such as Cohen, Bosworth and Robinson, that it ranges from 102 to 103, seldom more than 103, usually 102. In the treatment of tonsilitis I have never found a gargle effective In diphtheria or acute tonsilitis you can give chlorate of potash, or any other drug, but where a man has a pain in the angle of his jaw and a throat so sore he cannot swallow, if you can get him to gargle you can do more than I can. Ice held in the mouth until it dissolves is good, also powder or tincture of guaiac and tincture of aconite internally, but never give more than three doses of aconite in one day. Occasionally, if you see a case is going on to suppuration, use hot applications externally and internally in the way of steam, otherwise never use hot applications. My idea is that heat promotes conges-

tion more than cold, and my experience is that where cases are treated, some with cold and others with hot applications, that the cold in connection with other treatment, guaiac and tincture of aconite, is most successful. We ought to settle this question of tonsilitis. What is acute tonsilitis, and is there such a thing as acute tonsilitis? To me it is a misnomer. The abscess seldom forms in the tonsil, it is beind it in the loose connective tissue; and in opening it we cut behind or above the tonsil.

PROFESSOR C. W. EARLE said: I would like to ask Dr. Carter if there was any appearance of contagion in any of the cases?

DR. J. M. G. CARTER said: Frequently the disease will attack everybody in the family, old and young, and just as frequently but one or two in the family will have the disease. It sometimes appears to be contagious.

PROFESSOR G. C. PAOLI said: Tonsilitis is a very common disease in Chicago, especially among children. It is certain that there are different degrees of tonsilitis; there are light cases in which very little medicine is required, and again there are strumous children who are very susceptible to the changes of weather, and in inclement weather get wet and have tonsilitis. In some cases one tonsil is affected, in others both, or the pharynx. There are grave cases that cannot be cured in one week, or two, cases that develop into hypertrophy of the tonsils. In regard to treatment: a light case does not require ice, and a person with malignant scarlatina with tonsils affected would take cold from the application of ice. We should discriminate, and in malignant cases where the tonsils are inflamed should be careful about applying ice. In the use of aconite with children we should be very careful, as in fever it diminishes the circulation, and I would not recommend its general use unless you can see the patient two or three times a day and

watch the effect of the aconite. A simple thing to use is a little potash with tincture of iodine. In scarlatina complicated with diphtheria it is better to use very little medicine. I have nothing against chlorate of potash, however I read a very interesting paper by a professor in New York, his name I do not now remember, who says that observation has shown that chlorate of potash has often produced nephritis, and I think great care should be taken in its use.

DR. R. TILLEY said: One of the points brought forward by the author is the use of kerosene. I remember that Besnier, a professor of skin-diseases in Paris, says that kerosene is used extensively by the laity, but he regards it as a dangerous remedy in the hands of people generally, and a very inefficient one; he was speaking, it is true, of the treatment of itch. I protest against the use of the terms ozone and electrical conditions of the atmosphere: we know practically nothing about either.

DR. J. M. G. CARTER said that he was obliged to leave in order to take the train for Waukegan, and expressed regret that he could not remain and reply to the criticisms upon his paper.

PROFESSOR W. E. QUINE said: An interesting feature of the experience embodied in the paper is the obvious failure of the writer to differentiate infectious from non-infectious tonsilitis. I presume it is a matter of familiar observation to all who have been long engaged in the practice of medicine that many cases of follicular tonsilitis occur which baffle the judgment of the most experienced physician to determine with precision whether they are infectious or non-infectious. I have often seen in my own practice cases of this kind. Often one member of a family, probably the first one attacked, exhibits plainly marked features of simple follicular tonsilitis, and those of the

family who sicken afterwards exhibit the phenomena of diphtheria, or less frequently, scarlatina. The text-books do not give a reliable guide to diagnosis, and if any of my colleagues know of means by which cases of this kind can be differentiated with certainty we would like to know them.

One gentlemen has alluded to the opinion of an eminent professor in New York; I remember that Jacobi, who is perhaps the person referred to, in a recent article maintains very vigorously that many cases of so-called tonsilitis are in reality immature cases of diphtheria, and he stoutly maintains that there are many cases of diphtheria never having patches in the throat, and where the patient walks on the street and commu nicates the disease freely to those with whom he comes in contact.

PROFESSOR SARAH HACKETT STEVENSON said: Last February I was called to see a lady who had frequently suffered from tonsilitis. She was "subject to quinsy." I suggested that her child should not be kept in the same room with her as the case seemed more than ordinarily violent, and gave the usual treatment for quinsy; the disease went on to suppuration. I was called out of the city after one of the tonsils had discharged, and during my absence, about five days, her child was attacked with malignant scarlet fever, and died before my return. This is the first case in which I ever suspected that a benign form of tonsilitis might reproduce a malignant form. Since then I have watched all cases, however simple they may seem.

DR. C. T. FENN said: I think we should all take an interest in this work, especially in the most practical suggestions of Dr. Earle. The fact is, that to regard these cases all as malignant, is to be on the safe side. A case of simple tonsilitis has a tendency to develop into diphtheria. I protest against the folly of attempting to distinguish between mild and simple

cases of tonsilitis and diphtheria. In regard to treatment, I have no use for gargles or washes; I will not force open the mouth of a child and cause it to cry, but steadily and persistently, every fifteen minutes, I will give such medicines as the child will pass over the tonsils when swallowing.

PROFESSOR J. S. KNOX said: I regret that the paper is so general, the author evidently groups together a variety of cases of tonsilitis of different classes. There is undoubtedly an inflammation of the tonsils due to eruptive diseases, such as small-pox and scarlet fever, and there is a tonsilitis which is purely catarrhal, and another which is purely due to diathesis and which is rheumatic or syphilitic. The treatment differs accordingly. I think there is an error as to the value of chlorate of potash; better results will be obtained from the use of bicarbonate of potash, the value of the drug lying in the fact that it is a potash salt, and I think that the bicarbonate of soda would be still much more efficient. Where the hyposulphite of soda would do good, the salicylate would do more.

DR. J. J. M. ANGEAR said: It seems to me that if we remember that there is such a thing as resistance, the absence of which is susceptibility, it will explain some, if not all of these difficulties. We can readily imagine a robust, healthy child with strong resistance to morbid influences, and especially that of diphtheria, on exposure, would have simple tonsilitis (abortive diphtheria); but suppose that his brother, with strong susceptibility, is exposed to the same morbid influences, he will develop a case of undoubted diphtheria.

In diphtheria, we have an inflammation with fibrinous exudation which breaks down the mucous cells and forms the diphtheritic patch; this furnishes a nidus for the micro-organisms, which go on secreting or fermenting their peculiar virus, the absorption of which contaminates the whole body, and now

we have a constitutional disease. Will not this explain a large number, if not all, of those cases where four or five children in a family are taken down apparently with simple tonsilitis, and some one child that has not their resistance is attacked with undoubted diphtheria. In this house we have tonsilitis, and our neighbor severe diphtheria. By remembering these pathological facts, we shall see that it is, or it may be, all the same morbid influence here and yonder,—here, recovery in a few days; there, death in a few hours.

PROFESSOR F. O. STOCKTON said: In acute tonsilitis I think it will be found that ice is the proper treatment in the first stage, before suppuration has begun. It is very seldom that pus is located in the tonsil, it is behind the tonsil. With regard to a differential diagnosis between diphtheria and tonsilitis, there is almost always in diphtheria a regularly graded rise in the temperature; in acute tonsilitis, so-called, or follicular, the temperature is not regular, it rises at a jump, the attack comes on suddenly, begins with a chill immediately followed by fever; in diphtheria there is a gradual rise, going up one day, dropping the next. I think if we took a record of given cases of diphtheria and tonsilitis, we would find that a regular rise in temperature in diphtheria occurs as in the essential fevers.

THE AMERICAN ACADEMY OF MEDICINE.

The ninth annual meeting of the American Academy of Medicine was held in New York, October 28th and 29th.

The following papers were presented October 28th:

"The Study of Medicine as a Means of Education." By ROBET LOWRY SIBBERT, A. M., M. D., of Carlisle, Pa.

"Medical Supervision in Student Life." By CHARLES McINTIRE, JR., A. M., M. D., of Easton, Pa.

"Western North Carolina as a Health Resort." By HENRY O. MARCY, A. M., M. D., of Boston, Mass.

"The Importance of Climatology Considered as a Regular Branch of Study in Medical Colleges." By E. H. M. SELL, A. M., M. D., of New York.

At eight o'clock, P. M., Address, by ALBERT L. GIHON, A. M., M. D., Medical Director, United States Navy, President of the Academy:—"What is Medicine?"

After which the annual collation was participated in by the members.

During the second day's session the following papers were presented:

"Medical Evidence." By THOMAS J. TURNER, A. M., M. D., PH. D., Medical Director United States Navy.

"Report on Laws Regulating the Practice of Medicine in the United States and Canada. By RICHARD J. DUNGLISON, A. M., M. D., of Philadelphia, Pa., and HENRY O. MARCY, A. M., M. D., of Boston, Mass.

"Health Officers, Ancient and Modern." By BENJAMIN LEE, A. M., M. D., Secretary of the State Board of Health of Pennsylvania.

"Micro-organisms and their Relation to Disease." By SAMUEL N. NELSON, A. B., M. D., of Cambridge, Mass.

"Observations on the Relation of Bacteria to Certain Puerperal Inflammations." By ERNEST W. CUSHING, A. B., M. D., of Boston, Mass.

"Medical Licenses and Medical Honors." By EDWARD JACKSON, A. M., M. D., of Philadelphia, Pa.

"The Physician and his Patient." By JOHN DEVIN KELLY, A. M., M. D., of Utica, N. Y.

"Sketches of some of the Original Members of the Delaware State Medical Society." By LEWIS P. BUSH, A. M., M. D., of Wilmington, Delaware.

In his address the President of the Academy advocated an extension of the conditions of membership in the Academy, in the belief that its usefulness will be still further increased, The matter will be considered at the next annual meeting.

Relative to preliminary education for medical students, which has been one of the important objects for which the Academy was organized, the following resolution was adopted:

Resolved, That a committee of three be appointed by the President, to report at the next annual meeting, instructed to prepare a statement of the best preliminary education for medical students, and also a statement of the minimum attainment which medical schools should require of students before admitting them to the study of medicine.

It was also resolved that a committee of two be appointed, "whose duty it shall be to report on the requirements as to preliminary education of the various medical colleges in the United States and in Canada." The newly elected members of the Academy are:

Drs. S. M. Nelson, Cambridge, Mass; J. H. W. Chestnut, Philadelphia; Rufus W. Bishop, Chicago; E. E. Mariott, Springfield, Mass.; George N. Acker, Washington, D. C.; H. V. Logan, Scranton, Pa.; H. W. Elmer, Bridgton, N. Y.; H. F. Hansell, Philadelphia; E. W. Cushing, Boston, Mass.; J. S. Wight, Brooklyn, N. Y.; William Osgood, North Yarmouth, Me.; C. A. Packard, Bath, Me.; W. K. Oake, Aubern, Me.; A. Mitchel, Brunswick, Me.; D. A. Robinson, Bangar, Me.; C. A. Ring, Portland, Me.; J. A. Spaulding, Portland, Me.; G. W. Marshall, Milford, Del.; Wm. A. Hugie, Charleston, S. C.; J. B. Shapley, St. Louis, Mo.; M. H. Post, St. Louis, Mo.; C. E. Briggs, St. Louis, Mo.; J. S. Alleymen, St.

Louis, Mo.; N. S. Davis, Jr., Chicago, Ill., and Charles Edgar Cook, Mendota, Illinois. Dr. Henry H. Smith and Dr. S. Weir Mitchell, of Philadelphia were elected to honorary membership.

The following were elected as the officers for the ensuing year:

President—Dr. R. S. Sutton, of Pennsylvania.

Vice-Presidents—Drs. L. P. Bush, of Delaware; S. J. Jones, of Illinois; R. L. Sibbett, of Pennsylvania and F, H. Gerish, of Maine.

Secretary and Treasurer—Dr. R. J. Dunglison, of Pennsylvania.

Assistant Secretary—Dr. C. McIntyre, of Pennsylvania.

Pittsburg, Pa., was selected as the place for the next annual meeting, on the third Tuesday in September, 1886. The Academy then adjourned.

PHILADELPHIA ACADEMY OF SURGERY.

A meeting of the Philadelphia Academy of Surgery was held October 5, 1885, Vice-President Dr. R. J. Levis in the chair.

FOREIGN BODY CAUSING VESICAL CALCULUS.

DR. J EWTNG MEARS: I desire to present to the Academy a urinary calculus removed from a patient in St. Mary's Hospital three weeks ago. The patient was a man from the interior of the State, fifty-six years of age, who had been suffering with bladder-trouble for nine months. There had been difficult micturition with pain, and the diagnosis of inflammation of the bladder had been made. Six months ago, in order to relieve the difficulty in passing water, he said that he had introduced a straw some two or three inches long. He

was under the influence of liquor at the time, and the straw slipped from his grasp and entered the urethra. His symptoms then became more marked, and he came to this city. I introduced a sound, and discovered in the bladder the stone or mass which you see. The urine was carefully examined, and it was found to contain a large quantity of albumen and also phosphatic deposits. The question arose, in view of the man's habits, his age, and the condition of the urine, whether it would be better to perform lithotomy or lithotrity or litholaplaxy. Under the circumstances, I considered lithotomy the preferable operation.

I cut the man, and in so doing opened an abscess in the prostate, evacuating about an ounce of pus. I then entered the bladder and removed this cluster of calculi with a scoop. The bladder was then washed out, and in two weeks the man returned to his home with the wound entirely closed. At the end of this time, examination of the urine showed that its character was greatly improved.

It was certainly fortunate that section of the perineum was decided upon. The abscess was not recognized before operating, although exploration of the perineum was made. There was no pain, no swelling, and no tenderness.

The question arises, in such cases as this, where the age of the man, his habits, and the composition of the urine indicate serious vesical and possibly renal disease, whether it is better to perform lithotomy or the crushing operation.

DR. LEVIS: How would the introduction of a straw account for this fimbriated character of the mass? If a head of wheat or barley had been passed, it might explain it.

DR. S. W. GROSS: Close examination will show that this is a spear of some grain, and that these little calculi are formed around the hairs of the grain.

EXCISION OF THE SCAPULA.

DR. JOHN BRINTON exhibited a specimen of interest from the magnitude of the operation required for its removal. This was a sarcoma of large size, requiring the extirpation of the entire scapula in a child eleven years old. The operation was unsuccessful as far as the life of the child was concerned, as the patient sank rapidly from the shock, and died an hour after the termination of the operation.

The tumor was fifteen inches in circumference at its base. From the history given it seemed to have originated in a fall.

The child was suffering greatly. The pain during the day-time was paroxysmal, but at night almost continuous. The following is Dr. Brinton's description of his method of operating: "I made an incision, carrying it to the posterior edge of the scapula. The incision was not at first carried the entire length, because I wished to divide the acromio-clavicular articulation as soon as possible. The idea was to save every drop of blood that could possibly be saved. I had gathered from the reports of cases that the great peril was from hemorrhage. I therefore commenced with a moderate incision, so as to divide the acromio-clavicular articulation. The incision was then swept across to the posterior portion of the bone. An incision was next made at right angles, and the incision (somewhat curved) was carried below the angle of the scapula and the four flaps dissected up. Then I commenced at the upper part of the bone, dividing the muscles; and then passed slowly down, dividing the muscles,—taking the precaution, where there was any chance of considerable hemorrhage, to include the mass of muscle within a ligature before dividing it. Where there was no danger, a mass of tissue was grasped between two large forceps, such as I formerly used for the extraction of bullets. The incision was then carried along the

posterior border and the muscles divided; it was next carried under the inferior angle of the bone and the parts raised. The incision upon the anterior costa of the scapula was carried up, the vessels being compressed; and thus the parts being lifted, I opened the capsular ligaments and turned out the head of the humerus. I next divided the heads of the muscle attached to the coracoid process. I had already divided the muscles along the spine. The bone was then readily lifted up and the hemorrhage was comparatively small. Performing the operation in this way, only one or two vessels required ligature after removal of the bone."

The microscopical examination of this growth by DR. LONGSTRETH shows that it is a well-marked example of round-celled sarcoma.

One other case of complete excision of the scapula was performed by Professor Agnew some years ago. The patient died in a short time from shock. Two partial operations were performed by the late Professor GROSS.

DR. R. J. LEVIS described a method devised by him for a similar case, by which a rubber bandage was made to surround the shoulder and control the hemorrhage.

DR. BRINTON stated that there was no difficulty in compressing the subclavian artery with the fingers in this case.

CONGENITAL MALFORMATION OF COLON.

DR. CHARLES B. NANCREDE: I have here specimens of some little interest. They are the terminal part of the rectum and the caput coli, which were removed from an infant, 50 hours old. The child had been delivered with instruments, and seemed to be in perfect health until the second night, when the nurse sent for me and said that there was something wrong; that the child was crying and straining, but had not soiled any napkins.

On examination, I found a well-formed anus, into which I could introduce my finger one-third of an inch. It was a female child, and I could therefore make a thorough examination; but I could detect no bulging at any point. As it was twelve o'clock at night and the distention was not great, I gave an opiate, and the next morning at eleven o'clock DR. ASHHURST met me in consultation. Neither of us could feel any bowel, but we thought it right to make an effort to reach the bowel. I dissected along the hollow of the sacrum up to the promontory, but could not feel the gut. We then decided to perform the operation in the right inguinal region, and I opened what I supposed to be the sigmoid flexure; but it proved at the post mortem to be the caput coli. As soon as the peritoneal cavity was opened, about an ounce of serum escaped, and with it the right Fallopian tube, which was intensely congested. There was marked peritonitis. The child lived four and a half days after the operation. The meconium passed freely, and afterwards the discharges were natural. The child died from exhaustion, evidently due to the peritonitis.

The post mortem showed that if I had detected the bulging bowel, which I must have felt, as it was near the end of my incision, I should almost inevitably cut through two layers of peritoneum. There was a space about as wide as a director where the bowel was not covered by peritoneum, and I should have left behind the peritonitis. The question arises in these cases, if peritonitis does set in so early, and if death results, as it usually does, from peritonitis, whether it is worth while to add the double danger of two operations, especially in female children, where it is impossible to detect any sign of the bowel.

TREATMENT OF CARBUNCLE.

DR. JAMES COLLINS: I have lately treated two cases of carbuncle on the back of the neck, by a method which seems to

have some advantages. The patient is put under the influence of an anæsthetic and a linear incision made. I then take a scoop and remove all the necrosed tissue, and wash the parts thoroughly with an antiseptic solution of mercuric chloride. I then put in a drainage tube, and insert two stitches to bring the central part together. Each day the cavity is thoroughly washed out with the antiseptic solution. The patients have done well, and the cicatrix has been less than after any other method I have tried. The success depends upon the removal of the necrosed tissue and the use of the antiseptic solution.

DR. S. W. GROSS: The plan of Dr. Collins is, I think, based upon proper principles. I consider it far the best operation yet suggested. By scraping away all the dead tissue he gets rid of the micrococci which produce putrefaction, which give rise to the sloughs. The application of the corrosive sublimate destroys the micrococci which line the walls of the cavity, and in that way removes the cause of the disease.

NITROUS OXIDE GAS IN THE EXAMINATION OF FRACTURES.

J. M. BARTON, M. D., read a report of numerous cases of fractures examined while the patient was under nitrous oxide gas. One case of re-fracture of a radius to correct a faulty union was also detailed.

The agent was found to afford sufficient relaxation and freedom from pain to enable one to diagnose and adjust most fractures. Its advantages in all minor operations, of course, are familiar. That it does not cause nausea nor vomiting, even if the stomach be not empty, the slight risk, the immediate recovery permitting the patient to attend at once to his usual avocations, etc., are well known; but in fractures we avoid that period of excitement which appears during the administration of ether, and during which the patient is so likely to further injure the fractured limb.

The period of full anæsthesia is from one to two minutes, but the period of total muscular relaxation is nearly four minutes.

While the anæsthetic is being administered, the injured limb is fully exposed and held by the surgeon. Before the patient is quite unconscious the surgeon feels the limb become limp and lax in his hand; all the muscles are relaxed. The examination can now begin, though the patient gives some slight evidence of feeling pain. This period, the period of total unconsciousness, and the succeeding period of muscular relaxation, gives about four minutes, which will be found to be abundant time to examine almost any fracture.

The apparatus for administering nitrous oxide is now both cheaper and more portable than formerly. The dental depots supply the liquified gas in small receivers, thus doing way with the necessity of tanks and large rubber bags. Its use in surgery will probably increase, notwithstanding that it is slightly more expensive than chloroform or ether.

BOOK REVIEWS.

FOWNES' MANUAL OF CHEMISTRY. *New edition. Royal 12mo, 1056 pages. Philadelphia:* LEA BROS. & CO. *Chicago:* JANSEN, MCCLURG & CO.

The original work of Professor Fownes has been edited several times by Mr. Watts, and finally it became so much altered that it amounted to a new book. Shortly before his death, Watts had completed his "Physical and Inorganic Chemistry," and this forms a part of the present edition. It is no exaggeration to say the work thus improved is among the best ever offered to American students. J. H. L.

A COMPLETE PRONOUNCING MEDICAL DICTIONARY. *By* JOSEPH THOMAS, M. D., LL. D. *Philadelphia:* J. B. LIPPINCOTT & CO. *Chicago:* W. T. KEENER.

This is an enlargement and modification of another work by the same author, and is especially intended for the assistance of the large number of medical men who have never enjoyed the advantages of a full training in the ancient languages. Besides being a guide to pronunciation, it is quite full on the etymology of medical terms as far as this can be traced; which is certainly a valuable feature and one which will commend it generally. Yet it cannot be said that it fills its mission fully. J. H. L.

A TEXT-BOOK OF PHARMACOLOGY, THERAPEUTICS AND MATERIA MEDICA. *By* T. LOUDER BRUNTON, M. D., D. SC., F. R. S. *Philadelphia:* LEA BROS & CO. *Chicago:* JANSEN, MCCLURG & CO.

This work has been expected for some years, and in explaining the long delay, the author refers to the time spent in verifying numerous statements collected from various sources.

It is divided into several sections, treating of general pharmacology, general pharmacy, inorganic materia medica, organic materia medica, vegetable materia medica and the animal kingdom.

Each section is properly subdivided, following excellent systems, and pains have been taken to include matter of real interest and importance for those who will use it. On the whole, it seems to be one of the fullest and best works on the subject in the language. J. H. L.

ITEMS.

A NEW JOURNAL.—A prospectus has been issued, announcing the advent of a new journal, to be published by G. P. Putnam & Sons, of New York, and to be devoted, especially, to the discussion of crime, pauperism, insanity, and idiocy, and to the care of the defective and criminal classes. Although these interests are of great magnitude, so far no special journal seems to have been devoted, exclusively, to the consideration of them.

This one is to be under the editorial management of F. H. Wines, Secretary of *The Illinois State Board of Charities*, who has had large experience in this work. The first number is to appear next month.